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ABSTRACT

This handbook was written to share the feelings, experiences, and knowledge of parents of children with emotional disorders. The first chapter, "Feelings Come First," considers recognition of unusual behavior patterns underlying emotional disturbances and the difficulty of determining their causes, their impact on the family, and coping strategies. The second chapter, "Finding Some Help," briefly explains common models used to explain emotional disorders and common conditions, including pervasive developmental disorders, attention deficit and disruptive behavior disorders, schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, and eating disorders. It also discusses specialists who provide diagnosis and treatment and services such as wraparound services, home intervention, school-based services, community-based outpatient and day treatment, residential treatment, and respite services. The final chapter, "Understanding the Law," reviews the meaning of some common labels applied to children with emotional disorders; explores federal statutory and case law relevant to special education services; and addresses school and treatment problems (such as drug and alcohol problems, eligibility for out-of-home care, how parents can lose custody, and financial help and services). At the end of each chapter, exercises review the information or share attitudes and ideas with others. A glossary of acronyms, laws and regulations, and terms is provided. An appendix lists organizational resources. (Individual chapters contain references.) (DB)

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Taking Charge:

A Handbook for Parents Whose Children Have Emotional Handicaps

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**TAKING CHARGE:
A HANDBOOK FOR PARENTS
WHOSE CHILDREN HAVE EMOTIONAL
DISORDERS**

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TABLE OF CONTENTS

FOREWORD	1
CHAPTER ONE: FEELINGS COME FIRST	3
I. Feelings Come First	3
II. Impact on the Family	5
III. Coping with a Child with a Disorder	9
IV. Exercises	15
V. References	21
CHAPTER TWO: FINDING SOME HELP	23
I. What is Psychotherapy?	25
II. Common Conditions Exhibited by Children and Youth with Emotional and Behavioral Disorders	27
III. Specialists Who Provide Diagnosis and Treatment	35
IV. Services Available for Children and Parents	41
V. Exercises	49
VI. References	61
CHAPTER THREE: UNDERSTANDING THE LAW	65
I. Labels	67
II. Federal Statutory and Case Law	69
III. School and Treatment Problems	81
IV. Exercises	89
V. References	99
CHAPTER FOUR: GLOSSARY	101
I. Acronyms	101
II. Laws and Regulations	107
III. Terms	108
APPENDIX: RESOURCES	119

FOREWORD

For all parents, preparing for the birth or adoption of a child involves a great deal of planning, dreaming, and even fantasizing. The unfulfilled aspirations of the expectant parents become woven into their dreams for the new child.

All parents fantasize in this way, but few children ever grow up to fulfill all the dreams of their parents. Gradually, parents adjust to their children as they are with their own strengths, weaknesses, and human frailties. Even though the child may not have the beauty, talent or winning personality that parents dreamed about, the child has real skills and strengths which are a source of pride.

Most parents accept their children as they are and expect them to grow up reasonably normally. Some children, however, are different. They do not fit normal patterns of development. They may appear normal physically and may also have normal intelligence, but their behavior does not conform to accepted standards. These "different" children are the ones who may be labeled "seriously emotionally disabled," "seriously emotionally disordered" or as "having a serious emotional disorder."

We have written this handbook to share the feelings, experiences, and knowledge of other parents of children with emotional disorders with you. Our purpose is to let you know that you are not alone. There are other parents struggling with problems similar to yours who understand your feelings and frustrations.

The chapters included in this handbook are "Feelings Come First," "Finding Some Help," "Understanding the Law," and the "Glossary." At the end of each chapter, there are exercises to help you review information or share attitudes and ideas with others. You may want to read the chapters by yourself or with your spouse. You can use all or parts of them as a basis for discussion in your local parent support group. You may want to share some of the information with professionals working with your child.

When you have finished reading the chapters and doing the exercises, you should know more about the impact of emotional disorders on a family, the legal bases for help, and the types of mental health services that are or should be available. For further information, consult the references/bibliographies at the end of each chapter.

Reading this handbook can be the beginning of your growing understanding of what can be done to help children with emotional disorders. We hope you will want to learn more and that you will join with other parents to advocate for children and youth with emotional or behavioral disorders.

CHAPTER ONE

Feelings Come First

SECTION I: FEELINGS COME FIRST

Unusual Behavior

Parents assume that their child is developing normally until he or she behaves so differently that the unusual behavior cannot be ignored. As one father explained:

We thought Molly was a normal kid because we just didn't know any better. She was our first one. When she didn't sleep at night, we tried one thing after another—reading to her, rocking her to sleep, ignoring her, punishing her, even giving her cough medicine. Nothing worked.

Daytimes weren't so good either. When I was at work, my wife couldn't control her at all. She was so destructive. Not just getting into things, but actually destroying things and not seeming to care when we were upset.

When Molly turned three and neither one of us had had any sleep for weeks on end, we decided we just had to get some help. This couldn't be normal.

According to Henry Reinert and others, there are four general types of behavior which parents come to recognize as unusual:

1. **Acting-Out Behavior** (self-abusive, aggressive, violent, disruptive, cruel);
2. **Withdrawing Behavior** (absence of speech, regressing to babyhood, fears, depression, refusing social contact);
3. **Defensive Behavior** (lying, cheating, manipulating others, avoiding others); and
4. **Disorganized Behavior** (out-of-touch with reality, assuming multiple personalities, hallucinating).

A child may exhibit just one of these types of behavior or some combination of two or more of them.

Some of these abnormal behaviors are more severe than others. In fact, behavior problems range from mild problems which are resolved with short-term assistance, to moderate problems requiring intensive help, to severe problems demanding long-term care and specialized treatment.

Causes Difficult to Find

When a child behaves in unusual ways, it is difficult to say whether there is something wrong with the child or whether the child is reacting defensively toward abuse, neglect, violence, or other unfavorable circumstances in his or her environment. Is there a genetic, biological or neurological cause for the child's behavior? Or, is the child's behavior a result of imitating poor models? Is the child reacting to physical or emotional deprivation or merely behaving the way his own body and mind force him to behave?

The causes of emotional disorders are complex. Experts in the fields of mental health, psychology and psychiatry even disagree sometimes among themselves. In addition, each child who exhibits unusual or inappropriate behavior is different. There is no one theory or explanation of emotional disorders which applies to each child and his or her unique problems. When children belong to a culturally diverse group, whether by virtue of culture, social class, race, religion, family lifestyle or for other reasons, it is important that this factor is considered by experts in their assessment of the child's behavior and the family situation.

Parents face two problems: (1) accepting the fact that their child is not behaving or developing normally; and (2) dealing with uncertainty about why the child behaves strangely. The one certainty parents have is that their child has a serious problem which affects the family deeply.

SECTION II: IMPACT ON THE FAMILY

Parents' Reactions

Loss of Self-Esteem. No parent of a child who has an emotional disorder is prepared for the experience. No matter how self-confident or outwardly successful parents may be, the revelation that their child has an emotional disorder can be devastating to their self-worth. As one mother put it:

What did we do wrong? No one in our family has ever been mentally ill. Our other kids are normal. We treated them all the same. Why is this kid screwed up? What's the matter with us?

Sometimes parents reason: if we have a child with a "defect," we must be "defective" people. Even though parents are often not responsible for their children's emotional disorders, a sense of failure and loss is often experienced by parents.

Shame and Guilt. Because of their own emotional vulnerability, parents often willingly accept the blame for causing their children's illness. They may feel ashamed that their ability to love and discipline their child appears to have failed so completely. They wonder: Why do some parents seem to raise "model children" so easily, while we have tried hard with our child and gotten nowhere?

Sometimes parents blame each other. Deep-seated resentments in a marriage may come to the surface. Dislike of in-laws can become magnified. Spouses may blame each other's families for having "defective genes." Sometimes parents' religious backgrounds may cause them to feel that their child's behavior is the result of "God's judgment" on the family.

Feelings of shame and guilt come from the parents' strong sense of responsibility and desire to protect and nurture their child. Those feelings also come from a loss of pride. Their child has not turned out the way they expected. Their best efforts appear to have resulted in failure:

We had dreamed of having a little boy. At first, when we adopted Mel he seemed so bright and quick—just the child we wanted. Then we began to notice the odd behavior, the uncontrolled rages, the mean, belligerent remarks—even to total strangers. We were stunned. Our dream had become a nightmare.

Sorrow. Sorrow is a natural response to the "death" of the dreams and fantasies that parents have had for their child. Parents need a period to mourn the loss of the perfect

child they had in mind. Parents also mourn because they see their child suffering and causing others to suffer. Sorrow ebbs and flows throughout the child's illness.

Denial. On the other hand, some parents deny their child has a problem even in the face of abundant evidence of an emotional disorder. They pretend not to notice the child's strange behavior. They ignore temper outbursts, destructive behavior or episodes of lying and cheating--minimizing their importance or pretending they never happened. As families change their lifestyles and homes to adapt to the child's needs, they may not be aware of the extent of the child's difficulties. One mother said,

I knew he was gradually breaking all of the toys and furniture in his room, but I just kept cleaning up and hauling away the broken pieces as though nothing had happened. Disciplining him seemed to be such an effort and did no good. Soon his room was bare and scarred. I was ashamed to go in.

Withdrawal. When parents begin to realize that their child has an emotional disorder, they sometimes instinctively withdraw from their normal associations with other people. Emotional disorders are difficult to explain. Many parents avoid contact with other people because they fear what others will say, or they think no one else can possibly understand their problems. Some parents find it difficult to engage in normal family activities, such as going to a restaurant or to church, because of their child's unique behavior and needs. Often it is difficult to get out of the house because of the lack of baby-sitters available for their child with special needs or the lack of appropriate places to take children with emotional disorders.

Anger. Some parents become angry and lash out at each other, and at family and friends. "Why us?" they ask. "We have done nothing to deserve this." They are angry because their child is the victim of a condition which is difficult to diagnose and treat. They are angry, too, because they cannot find services for their child, they may not be able to afford the services, because laws and interagency squabbles interfere with getting help, and because family and friends are too fearful and uncomfortable to offer comfort and understanding.

Depression. The responsibility for the care and nurturing of a child with an emotional disorder sometimes overwhelms even the most steady parent. Depression hits, especially on those days when the child has been the most out of control or the most withdrawn. The long haul, the up-hill fight, of raising such a child sometimes appears to be too great a responsibility and the parent may have times of discouragement and depression.

Concern. Many times parents have difficulty convincing others of the seriousness of their child's problems. They fear that their child will not get help in time--that he or she might harm themselves or someone else or do serious damage before treatment is available. Parents fear the future. They have few guidelines to tell them what to expect

or how to manage the situation; therefore, they have many questions in their minds: How will we care for this child? What does the future hold? Will he/she get worse? Can we afford treatment? There are many unknowns to face, and parents fear they will not have adequate personal resources to manage all that may be in their child's future.

Ambivalence. For some parents, their most frightening and bewildering emotions are their mixed feelings toward their child with a disability. On the one hand, they love their child and want to help him or her. But they dislike the child's behavior, the burden it places on the family, and the pain it causes those who know the child. Parents may experience feelings of rejection and anger toward the child, and then feel guilty for having those negative feelings. At times they may be overwhelmed with love and feelings of protectiveness toward the child. One father tearfully expressed his mixed feelings this way:

I found myself hating my own kid, wishing he had never been born. I saw what he was doing to my wife, the way my daughter hid from him—I knew he was destroying us and I hated him for it. Yet, deep inside I loved him so strongly. He was ours and meant so much to us. How could I hate my own son?

Confusion. Perhaps the most common feeling experienced by parents of children with an emotional disorder is a sense of confusion or loss of control. Because the discovery of serious problems in a child always comes as a shock, parents are often overwhelmed by a rush of conflicting feelings. They want to love and protect their child, but at the same time their minds are flooded with fears, doubts, guilt, anger, sorrow, worry and shame. Their lives seem suddenly out of control because their child's behavior is so unpredictable and so different from what they expected.

Many parents report that in the beginning of their confused state they are unable to grasp information or to process what is going on around them. Their moods swing wildly from hopefulness to depression. They run around trying to do one thing after another, never finishing one task before starting another. Or they stop being active and withdraw, and sit for hours unable to move or function. Their feelings change from moment to moment.

For some parents, loss of control over their personal lives leaves them with a sense of powerlessness. While they realize the need to be strong and supportive for their child's sake, they are uncertain about what to do next. It may be hard for them to recognize their own strength, skills and courage.

Other Family Members' Reactions

The brothers and sisters of children who have emotional disorders can be deeply affected by the behavior of their brother or sister. Siblings sometimes become angry because their

brother or sister with the disorder is destructive and hurts them or ruins their things. Sometimes brothers and sisters are embarrassed by a sibling's odd behavior, or they are jealous because that sibling receives so much of their family's attention. While it is easy to have sympathy for a child who has a physical illness or disability, it is not as easy to feel sympathetic toward a brother or sister who behaves oddly.

Grandparents and other adult relatives, depending on the amount of exposure they have to the child with an emotional disorder, may experience many of the same emotions parents feel. If they live at a great distance, they may also experience a sense of helplessness because they cannot do anything on a daily basis to assist the family. In cultures and ethnic groups that rely on extended family or multiple caregivers, relatives and grandparents may need to be considered as a resource to the family. Grandparents, aunts and uncles may be the family's greatest source of strength and help.

SECTION III: COPING WITH A CHILD WITH A DISORDER

Families are amazingly resilient. They hope when it is unreasonable to hope; they bounce back when no one expects that they will. Even the most formidable problems associated with emotional disorders do not stop parents from loving their children and doing what they have to do to sustain their family and help the child.

Coming to Terms with Feelings

Parents and family members of children who may have an emotional disorder have a particularly difficult challenge. It is natural for them to begin to think they are the cause of the problems and have a disorder themselves, especially when blame is heaped upon them by "professional experts." As one father put it:

Everywhere we turned someone had something negative to say about the way we raised our son. They questioned us about everything we did. They blamed us for Ron's crazy behavior. We were exhausted and began to think they were right. Maybe we were crazy!

For families of cultural, racial or sexual diversity, expressing this dilemma to professional experts, particularly those of the dominant culture, may be especially demoralizing, inappropriate, or stigmatizing. In situations where their child gets involved with multiple systems, the juvenile justice system or children's protective services, for example, parents may feel frightened and overwhelmed. Families may want to be accompanied by an advocate or other ally with experience in similar situations when attending meetings with service providers.

When parents must deal on a daily basis with the difficult behavior of such a child, they are under tremendous strain. They have all the responsibilities other parents have, plus the added burden of dealing with behaviors that are extreme and unpredictable. It is normal and expected that these parents will experience strong emotional reactions to their situation. Their emotions are a part of the human process of facing the problems of having a child with a disability.

Advice from Other Parents

Parents who have coped with their own feelings have strong advice for other parents who are just beginning the process:

1. *Refuse to Feel Guilty.* No parent or family is perfect. Accept the fact that you have done your best. The needs of your child are beyond the usual and beyond

what you alone can provide. That is okay. To help your child, you have to refuse to be weighed down by guilt. So what if you are "guilty"? Does it help? What matters are the things that can be done now for the child and for you.

If you cannot shed the guilt on your own, get some professional help for yourself. The first battle is accepting yourself;

2. *Be Realistic about What You Can and Cannot Do.* No one who understands your situation expects you to be supermom or dad. Sometimes professionals do have high expectations for you and your family, and you will have to help them see your family situation more realistically. There are legitimate limits to how much time, energy and emotional tolerance you have for your child with special needs. You must assess your limitations, accept them, and insist that others accept them. This is a tall order, but it is also the only way that you can continue to be of use to your child.

When you know your limitations and have accepted them, you are better able to accept the help professionals can provide. It may be very tough, for example, to accept the fact that a foster parent or a special education teacher is more effective with your child than you are, but if they truly are more effective, you certainly do not want to be the one standing in the way of your child's getting the help he or she needs; and

3. *Get Some Support.* Being the parent of a child with an emotional disorder does set you apart. It can be lonely. You need emotional support for yourself. Some parents find that support in a close friend or family member who provides unconditional love and acceptance. Others turn to church or counseling groups. Many parents whose children have emotional disabilities find comfort in making connections with other parents whose children have similar disorders. In any case, you must find help and support from at least one sympathetic adult.

It is helpful to be told over and over again by someone you trust that your feelings are normal and that you are a valuable, worthwhile person. The time and emotional energy you give your child must be replenished so that you can go on giving.

Accepting the Child. At some point, you have to make a conscious effort to see your child as he or she is--without excuses or cover-ups. Once you have this clear picture in mind, you have to accept what you see. This is your child--a child first, a person you love simply because he or she is there.

You must then acknowledge your child's disability. That does not mean you have to like it. An emotional disorder is not something you would choose for your child. But it is a

real, undeniable fact--a problem to be faced squarely and dealt with. A young mother explained how she came to terms with her child this way:

For a long time I just hated Lonnie. I hated him for ruining my life, for causing the divorce, for being around at all. I could hardly look at him sometimes because he seemed to be the source of all my problems.

Then I looked again--really looked--and saw the lost, frail child who had been there all along. Lonnie did not choose to be sick. At that moment I loved him so much and felt so bad for all that I had been thinking.

Taking Action. Once you have faced the problem squarely, you are ready to take action. Experienced parents who have been successful in helping their children suggest doing the following things:

1. *Be Specific About the Problem.* When you seek help from professionals, clearly identify the problem. Such statements as "Johnny is impossible" or "Mary never minds me" do not give a complete picture of the kinds of behavior which have been troublesome. The professionals you consult may not be convinced that there is a problem unless you can give them specific information about:
 - a. how long your child has had problems;
 - b. how severe the unusual behaviors are;
 - c. how often the child behaves inappropriately; and
 - d. what specific behaviors are troublesome.

Cultural and racial culturally diverse families who don't feel comfortable relating information to professionals may want to consult with members of their community who are more knowledgeable in dealing with agencies before talking with their child's service providers. If possible, they should seek help from professionals who understand cultural and language differences. Otherwise, professionals may misconstrue parents' feelings and observations due to their lack of cultural and racial awareness;

2. *Know What You Are Talking About.* Keep records of your observations of your child. Keep copies of all the information you receive from individuals working with your child. Be prepared to present your information in a clear, organized fashion with facts to back up your claims;
3. *Keep Talking to People.* The mental health field is constantly in flux. New programs and new ideas spring up overnight. It is wise to maintain a healthy skepticism about much of what you hear and read, but it is also important to remain alert. One of these new programs or ideas may fit your child's case and prove to be very useful;

4. *Research the Problem on Your Own.* There is no reason why you cannot research your child's problems on your own. Go to the library. Consult the scientific literature. Look up terms you do not understand. Because you are likely to be persistent, you may run across an idea which professionals working with your child have overlooked;
5. *Consider What You Are Told in Relation to What You Have Observed.* Don't accept a diagnosis or suggestion for treatment from professionals unless it matches what you know from experience about your child. You are with the child more than anyone else. Your observations are certainly valid pieces of information. If a professional's diagnosis and/or suggestions for treatment do not match the facts as you know them, seek another opinion;
6. *Think it Through.* Take time for yourself for quiet reflection on your child's problems and the solutions which appear to be available. Do not be forced into quick decisions in the doctor's office or at a school conference, if you are not ready to decide. Given your thorough knowledge of the child, you may develop an alternative plan to that suggested;
7. *Find the Right Specialists.* In the mental health field there are a number of types of professionals. In addition, this field seems to attract a variety of unqualified practitioners who may take advantage of vulnerable parents. It is critical to choose the right specialist to diagnose and treat your child. See Chapter Two of this handbook for information about mental health professionals;
8. *Check Out the Professionals.* Be sure to make inquiries about the professional's credentials. In some states it is possible to advertise yourself as a therapist without having any particular training or license. Consult professional societies like the county medical association and state licensure boards for social workers, psychologists and therapists to make sure that the professional you are seeing has appropriate training. Members of culturally diverse families and those of non-mainstream lifestyles might want to look for professionals of the same ethnicity or culture or who have experience with similar families. You may also want to ask professionals directly if they feel that they can work effectively with your family;
9. *Trust Your Instincts.* After being through so much, you may begin to doubt your own wisdom, but do not give up on yourself. Parents are often right about children's needs and should advocate so that their opinions are heard; and
10. *Put the Child First.* Once therapy and treatment have begun, it is easy to get caught up in details and forget your child. No matter what program you are following, do not lose sight of the child. Spend time on family relationships and work through problems with the child's needs foremost in your mind.

Accepting the Disorder. Determined parents can be outstanding detectives, seeking out information and assistance for their child, but eventually there comes a time when they must decide to stop searching and accept those aspects of the child's emotional disability which cannot be changed. In some cases it may be necessary to set aside hopes for the "big cure" and become content with more modest gains and smaller steps forward. With some emotional disorders, a child may have to be on medication for the rest of his life. In other cases, the individual may always have some emotional limitations or may need long-term care and therapy. Accepting these limitations helps parents to shift emphasis away from the search for cures and toward realistic goals for treatment and daily living.

The process of adjusting to living with a child with special needs requires a great deal of hard work, soul-searching and individual development to meet challenges that arise. Parenthood does not automatically confer superhuman strength and abilities. Parents grow into the role, summoning the resources they need from family, friends and religion or personal philosophy. Some people do not have the resources to make the necessary adjustments; others must grow into the role at a very gradual pace. But most parents, in their individual ways, come to accept their role as a parent whose child has special needs.

Becoming an Advocate. During the time when parents are coming to terms with their child and his or her disability, they tend to look inward and to be concerned with their family and their individual needs. Gradually, as coping with the situation becomes easier, parents can begin to look outward again. In the process of coping with their own child, parents learn many skills which they can use in advocating, not just for themselves, but also for others.

There is a need at many different levels for parents to be advocates for their child and for all children with emotional disorders in their school district, home community, state and nation. Historically, mental health services have developed as a result of parents, relatives and friends of those with disabilities working and pushing for what they needed. Improved services have come about, not so much because of public sympathy or concern for those with mental illness, but because parents and others have applied enough pressure. No matter how small, every effort to affect needed change moves the system one step further along the road toward richer, more productive lives for children and youth with behavioral and emotional disorders.

There are numerous groups and organizations that can help you advocate for your child. These groups include the Federation of Families for Children's Mental Health, the National Alliance for the Mentally Ill-Child and Adolescent Network (NAMI-CAN), and the ARC (formerly the Association for Retarded Citizens, all of which have local chapters and have demonstrated good advocacy skills. The addresses and telephone numbers for these and other organizations are listed in the Appendix.

Members of culturally diverse groups might want to consult advocacy organizations such as LULAC (League of United Latin Citizens) or the G.I. Forum, the National Urban

League or NAACP (National Association for the Advancement of Colored People), tribal or other Native American organizations, ACLU (American Civil Liberties Union) or NOW (National Organization of Women) for advocacy approaches or techniques. Families may also need the support of church or other community and civil rights organizations.

There is much that still needs to be done. Many young people with serious disorders do not get any services. Frequently, there are legal obstacles to receiving the services which are available. Support services to relieve the stress on parents are lacking in many parts of the United States. In most cases, we know what services would be beneficial, but we have not allocated the resources to provide those services. When faced with the lack of services, one father put it bluntly:

It made me so damned mad that my daughter needed help and there just wasn't any available at any price. The only way to get her treatment was to give her up to the state and I wasn't about to do that.

Getting mad made me see that something had to be done and that I was the guy who better do it. No politician was going to care about my child unless I made him do it.

Parents can make a difference in the mental health system. When you are ready to reach out, there are other parents who will join you in efforts to inform the public and to influence political and social decision-makers. As an informed parent, you can take control of your own situation and do a great deal to assist your child and others in receiving appropriate treatment, education and support.

SECTION IV: EXERCISES

Questions: The following exercises provide an opportunity for you to think about what you have read. The page numbers for each exercise indicate the section of the text on which the questions are based. Answers for the exercises are on page 19.

EXERCISE 1.1: Section I (pp. 3-4)

Determining whether a child has an emotional disorder depends on three factors:

1. How severe the child's inappropriate behavior is;
2. How long the child has acted strangely; and
3. In what situations the behavior occurs.

Based on these three factors--severity, duration, and appropriateness for the situation--indicate which of the following children display behavior which you think possibly reflects an emotional disorder.

1. *Steve* broke down in tears several times in his third grade class during the week following his father's death. ☐ Yes ☐ No
2. Every afternoon alone in her room, sixteen-year old *Mary* sucks her thumb and stares into space. She can frequently be heard talking to herself and humming a tune. ☐ Yes ☐ No
3. Eleven-year old *Sara* flies into a rage when a sixth grade classmate brushes past her in the hall. Sara shouts an obscenity, picks up a nearby wastebasket, and hurls it at the lockers. ☐ Yes ☐ No
4. *Mike*, who is three, throws himself on the floor and has a tantrum when his parents tell him "no." ☐ Yes ☐ No
5. Four-year old *Susie* does not talk. At preschool, she rocks quietly and spins the knobs on the toy stove. She grabs snacks when they are offered and often steals food from the other children. ☐ Yes ☐ No

EXERCISE 1.2: Section 1 (pp. 3-4)

Read the following case studies and decide which type of behavior the child is displaying:

- A=Acting-out
- B=Withdrawing
- C=Defensive
- D=Disorganized
- E=Normal

- _____ 1. A shy girl, *Shannon*, seldom speaks up for herself. Frequently, others answer before she is ready to respond. As the number of her failures has increased, Shannon has begun to doubt her ability to succeed in any situation. Gradually, Shannon has refused to try any new activities, offering the excuse of not feeling well. Eventually, she adopted the attitude of an invalid and says she is too sick to participate in any activity.
- _____ 2. *Kenny* says he does not know his name. He does not know who he is. Though he is a good-looking ten-year-old with an excellent vocabulary, his conversation often does not make sense. He appears to be talking to people who are not present. He screams for no apparent reason. At night, he seldom sleeps more than an hour or two. He wanders through the house, opening and closing doors and calling out.
- _____ 3. *Mark*, who is three, has begun to bite his playmates at preschool. If another child takes a toy from him, he will bite that child. He seems unconcerned if the other child cries, but responds if the teacher tells him "no."
- _____ 4. *Sean* makes up stories about his family which he tells his fifth grade class each day. Even when other students openly make fun of his obvious fantasies, Sean persists in telling his stories. The teacher has confronted Sean about his lies, but he earnestly denies that the stories are untrue. Lately, he has begun to draw fantastic pictures of his family members suffering horrible tortures. Other children are shocked by the drawings, but Sean does not seem to notice.
- _____ 5. *Marilyn* loudly demands the teacher's attention. She pushes her way to the head of the line whenever her second grade class leaves the room. If another child reminds Marilyn to wait her turn, Marilyn strikes out, often knocking other children to the ground. Sometimes Marilyn locks herself in the bathroom stall and defecates on the floor. No amount of scolding or punishment changes her behavior. She appears to enjoy hurting others and doing shocking things.

EXERCISE 3.1: Section 3 (pp. 9-14)

The following statement describes one person's attitude toward being a parent whose child has special needs. Read through the statement and respond from your own experience to the questions that follow. There are no right or wrong answers. As a result of thinking about your answers, you should develop some insight into your own attitudes.

Parents of special children are special people. They are uniquely chosen by God to have children with disabilities because they are *uniquely gifted*, capable of incredible love and unstinting dedication.

1. Do you see yourself as "uniquely gifted" to care for a child with special needs? Why or why not?

2. Do you think that parents of special children are "special people"? Why or why not?

EXERCISE 3.2: Section 3 (pp. 9-14)

Agree or disagree with the following statements: A=Agree
D=Disagree

- _____ 1. For parents whose children have an emotional disorder, "the first battle is accepting yourself."
- _____ 2. Parents need "emotional information" about themselves.
- _____ 3. You have to make a conscious effort to see your child as he or she is.

- _____ 4. It is wise to maintain a healthy skepticism about much of what you hear and read in the mental health field.
- _____ 5. There is no reason why parents, on their own, cannot research their child's problems.
- _____ 6. Parents should not accept a diagnosis or suggestion for treatment from professionals unless it matches what they know from experience about their child.
- _____ 7. All parents have the resources to deal with a child who has an emotional disorder.
- _____ 8. Feelings of guilt are normal for parents whose children have emotional disorders.
- _____ 9. Knowing the causes of emotional problems leads directly to solving those problems.
- _____ 10. Parents are good observers of their children's behavior.

EXERCISE 3.3: Section 3 (pp. 11-14)

Complete the following sentences in your own words.

1. I see myself becoming an advocate for services for children with emotional disorders when . . .

2. What I need most as a parent is . . .

ANSWERS

Exercise 1.1 (p. 15)

1. **No** Steve's behavior probably does not reflect an emotional problem. Given his situation (father's recent death) and his age, his behavior is normal and to be expected.
2. **Yes** Mary's behavior indicates a need for further evaluation. A sixteen year old who sucks her thumb (very inappropriate for her age) and spends a great deal of time alone may indeed be experiencing emotional problems.
3. **Yes** Sara's reaction to a casual bump in the hallway appears to be extreme for the situation. Further investigation of her behavior patterns appears to be appropriate.
4. **No** Unless Mike has frequent uncontrollable tantrums and/or other problematic symptoms, his behavior seems to be normal for his age.
5. **Yes** Susie's behavior is of real concern. She displays a long-term pattern of not talking and associating with others. Her aggression at snack-time is extreme for her age. Susie probably should be evaluated for behavior problems.

Exercise 1.2 (p. 16)

1. Shannon is displaying *withdrawing* behavior.
2. Kenny is displaying *disorganized* behavior.
3. Mark is displaying *normal* behavior.
4. Sean is displaying *defensive* behavior.
5. Marilyn is displaying *acting-out* behavior.

Exercises 3.1 (p. 17), 3.2 (p. 17) and 3.3 (p.18)

Answers to these questions will vary.

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CHAPTER TWO

Finding Some Help

Finding help for a child with an emotional or behavioral disorder can be a difficult task for a parent. Many times parents find themselves getting the runaround from a variety of agencies. One mother described her dilemma this way:

We called the psychiatrist and the social worker and said, "What do we do? Where do we go for help?" They had no idea where to go or what to do. Their only solution was to "Hang in there. Things will get better." Things weren't getting any better. Tommy was completely out of control. He heard voices. The voices told him to kill people. He was stealing. He couldn't function at school. He was failing all of his classes. We called the school again and asked, "What can we do as parents to get some help for Tommy?" Their response was, "We don't know. There is nothing we can tell you. There's no place to go. You're a parent, so you deal with it."

Like this mother, many parents are left alone to find help the best way they can. For them, the mental health field is a confusing array of theories, varieties of therapy, and types of services. This chapter is meant to assist parents as they search for general information about emotional disorders and about services and therapies available. While this chapter is introductory in nature, it does contain references and a bibliography with information about materials that go into greater depth on mental health subjects.

SECTION I: WHAT IS PSYCHOTHERAPY?

Psychotherapy is a broad term meaning the treatment of mental or emotional disorders. Sometimes psychotherapy is confused with the more specific term psychoanalysis, referring to a treatment model based on the theory that mental disorders are caused by significant emotional events in the individual's past. Psychoanalytic treatment involves exploration of the patient's past to find the causes for current behaviors.

Psychoanalytic therapy is, however, just one form of psychotherapy. Other therapies based on different models include: (1) non-directive; (2) supportive therapy; (3) confrontive therapy; (4) behavior modification; (5) humanistic therapy; (6) family and milieu therapy; (7) play therapy and many more.

Models To Explain Emotional Disorders

Behavioral Model. Behavioral theory is based on the concept that all behavior, including inappropriate behavior, is learned. Behaviorists are not interested in finding the "causes" of emotional disorders. Rather, their emphasis is upon bringing about positive changes in the patient's behaviors. Behavioral therapists try to determine what is supporting or maintaining behaviors, and then they try to change those behaviors by providing positive reinforcement for desirable behaviors and, when necessary, ignoring (known as extinction) or using negative reinforcement for undesirable behaviors.

Biological Model. In the biological model, it is assumed that the cause of emotional disorders is some physical problem. The basis of the problem may be caused by some abnormality in the individual's physical or genetic makeup; or the problem may be environmental, caused by factors such as poor nutrition, birth or accidental injury, allergies, physical illness, poisoning, or poor sleep habits. The therapy used in the biological model involves treatment of the behavioral symptoms with drugs and/or by changing the patient's physical environment to remove the detrimental conditions (i.e., changing diet, improving sleep habits, etc.).

Ecological Model. In ecological theory, the therapist assumes that the causes of the patient's problems can be found in the interactions between the individual and his or her environment. Treatment in this model involves simultaneous intervention with the individual and with his or her surroundings. Family therapy, which involves intervention with family members and family interactions as well as with the individual and school-based interventions with classrooms are examples of ecological therapies.

Interactive Model. A variation of the biological model is the interactive model which suggests that emotional disorder is the result of a complex set of interactions between a basic physical abnormality and environmental and social "triggers" which activate or

aggravate symptoms of emotional disorders. Treatment based on an interactive model may involve a combination of strategies, including drug therapy, behavior modification techniques, counseling, and family therapy.

Psychoanalytic Model. Interventions based on psychoanalytic theory treat mental and emotional disorders by analyzing the facts of the patient's mental life. The causes of illness are assumed to be the result of psychological problems or conflicts which began sometime in the patient's past. Psychoanalytic therapy helps the patient by providing insight into present behavior through an analysis of conflicts in the individual's past.

There are a number of significant types of psychoanalysis, including the most famous and influential--Freudian Theory--as well as other theories such as Rogerian client-centered theory, Ellis' rational/emotive system, Schultz and Burton's encounter movement, Glasser's reality therapy, Jungian analysis and Adlerian therapy. Some therapists adhere to just one of these theories, while others describe themselves as "eclectic" and draw on ideas and techniques from a number of perspectives.

SECTION II: COMMON CONDITIONS EXHIBITED BY CHILDREN AND YOUTH WITH SEVERE EMOTIONAL DISORDERS

The American Psychiatric Association has developed a classification system for mental, emotional and behavioral disorders. The current revision of this classification, the Diagnostic and Statistical Manual of Mental Disorders (4th Ed. Revised (DSM-IV(R))), includes a list of disorders first evident in infancy, childhood or adolescence and disorders that appear in adolescence or adulthood. Below are descriptions of some of these disorders with brief, identifying definitions. (The notation "NOS" after the diagnosis stands for "Not Otherwise Specified.") For more information about these and other disorders, consult the references/bibliography pages at the end of this chapter. The Appendix has the names, phone numbers and addresses of some of the national organizations that have information about specific disorders.

Pervasive Developmental Disorders

Included among these disorders are Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Developmental Disorder (NOS).

Pervasive Developmental Disorder (P.D.D.). The term pervasive developmental disorder refers to a group of conditions marked by distortions, deviations and delays in the development of social and motor skills, language, attention, perception, and reality testing.

Autism. Autism begins before the age of 30 months and is characterized by a failure to develop the usual relatedness to parents and other people. As infants, these children may lack a social smile, avoid eye contact, and fail to cuddle. These children also fail to develop normal language and may use non-verbal commands in place of speech. Some children with autism develop echolalia, that is, the meaningless repetition of what is said by others.

The activities and play schemes of the child with autism are rigid, repetitive, and lack variety. Children with autism may manifest over- or under-responsiveness to sensory stimuli, for example to sound or pain.

The intellectual functioning of children with autism may range from profound retardation to normal levels. About 75 percent of children with autism have some degree of retardation.

Attention-Deficit and Disruptive Behavior Disorders

This category includes Attention-Deficit/Hyperactivity Disorder, Conduct Disorder, Oppositional Defiant Disorder and Disruptive Behavior Disorder (NOS).

Attention Deficit Disorder is a condition characterized by low attention span, impulsivity and/or overactivity in which behaviors are inappropriate for the age of the child. A.D.H.D. begins in early childhood; the symptoms of the disorder are generally chronic, occur across situations (i.e., at home, at school, with peers.) Children who have been diagnosed as having A.D.H.D. may experience a number of cognitive, academic, emotional, social and physical problems in addition to their primary disorder. These children may have problems in academic achievement, depression, low self-esteem, and poor peer acceptance.

Some experts believe that the signs of this disorder can be identified in early infancy. Infants with a difficult temperament, who are excessively active, have poor sleeping and eating habits, and are negative in their mood appear to be at greater risk for later A.D.H.D.

Conduct Disorder is a persistent pattern of conduct in which the basic rights of others and major age-appropriate societal norms or rules are violated. The behaviors must occur over time, not just isolated antisocial acts. Some youngsters first manifest symptoms during childhood; others develop symptoms in adolescence.

Conduct disorders may be mild, moderate or severe in nature. Mild forms tend to dissipate as a child matures, but more severe forms are often chronic. Conduct disorders appear in many settings, including the home, the school, with peers, and in the community. Children with conduct disorders are often physically aggressive and cruel to other people and animals. They may set fires, steal, mug, or snatch purses. In later adolescence, they may commit more serious crimes, such as rape, assault, or armed robbery. These children typically lie and cheat in games and in schoolwork. They are often truant and may run away from home. Children with conduct disorder often show no concern for the feelings of others and fail to show remorse or guilt for harm they have inflicted.

A child is considered to have conduct disorder if he or she meets specific behavioral criteria. Persistent antisocial behavior, not just isolated antisocial acts, is required to justify this diagnosis. These children project an image of toughness, but usually have low self-esteem. They often have other difficulties as well, such as depression, low problem-solving skills, learning disorders, and problems with substance abuse. A large number of these children are also diagnosed as having attention-deficit/hyperactivity disorders.

Children with an **Oppositional Disorder** display their aggressiveness by patterns of obstinate, but generally passive behavior. They appear to be conforming, but they continually provoke adults or other children. By the use of negativism, stubbornness, dawdling, procrastination, and other measures, they covertly show their underlying aggressiveness.

Other Disorders of Infancy, Childhood, or Adolescence

In this classification is found Separation Anxiety Disorder, Selective Mutism, Reactive Attachment Disorder of Infancy or Early Childhood, and Disorders of Infancy, Childhood or Adolescence Not Otherwise Specified.

An **Attachment Disorder** is a condition in which individuals have difficulty forming loving, lasting, intimate relationships. Attachment disorders vary in severity, but the term is usually reserved for individuals who show a nearly complete lack of ability to be genuinely affectionate with others. They typically fail to develop a conscience and do not learn how to trust.

A child with **Separation Anxiety Disorder** becomes anxious when separated from familiar persons or territory. Anticipated separations may cause the child to complain of physical illness and, after the separation occurs, the child may be inconsolable and fearful that a loved one may not return or may be prevented from reuniting with the child due to some terrible tragedy. Onset of symptoms are usually reported during preschool years and the most extreme form of the disorder is reported in prepubertal children, who may refuse to go to school to avoid being separated from their loved one. Symptoms may include unrealistic worry; avoidance of being alone in the home; reluctance to go to school; physical symptoms (e.g., stomachaches, headaches, nausea, vomiting) on school days; social withdrawal; apathy; sadness; or difficulty concentrating on work or play when not with a major attachment figure.

Schizophrenia and Other Psychotic Disorders

This includes Schizophrenia, some Psychotic Disorders, Schizoaffective Disorder and Delusional Disorder.

Schizophrenic Disorders. Schizophrenia is a broad term encompassing a number of clusters of symptoms which may vary over time. In general, the term refers to a psychotic disorder characterized by loss of contact with environment and by disintegration of personality. Symptoms of the illness may include: hearing one's thoughts spoken aloud, auditory hallucinations that comment on the individual's

behavior, imagined illnesses or pains, the experience of having one's thoughts controlled, the spreading of one's thoughts to others, delusions, and the experience of having one's actions controlled or influenced from the outside. The onset of schizophrenia usually occurs in young adulthood but symptoms can develop in individuals as young as 15.

Mood Disorders

Included in the Mood Disorders are Depressive Disorders and Bipolar Disorders.

A mood disorder refers to a disturbance of mood and other symptoms that occur together for a minimal duration of time and are not due to other physical or mental illness.

Bipolar Disorder. In this disorder, there is a distinct period during which the child's predominant mood is elevated, expansive or irritable, usually accompanied by a major depressive episode. The manic episode consists of an elevated mood that may be described as euphoric, unusually good, cheerful or high; but those who know the person will recognize it as excessive. The disorder is severe enough to impair normal activities and relations with others. Manic episodes usually begin suddenly with symptoms intensifying over a few days. Episodes may last from a few days to months.

Manic symptoms may include inflated self-esteem, decreased need for sleep while feeling full of energy, loud and rapid speech that is difficult to interrupt, continuous flow of speech with abrupt changes of topic, distractibility, restlessness, increased sociability, and disorganized, flamboyant or bizarre activities. There may be rapid shifts of elevated mood to anger or depression.

Depressive symptoms may include sadness, loss of interest in usual activities, and sleep and appetite disturbances. Older children may express feelings of worthlessness and guilt, difficulties in thinking or concentrating, and suicidal thoughts or recurring thoughts of death.

Depression is a type of mood disorder which may occur singly, recurrently, or accompanying a manic episode as bipolar disorder. Children may look sad, express hopelessness, lose interest in their usual activities, sleep more or less than previously, have a poor appetite, and say they feel tired. However, depression is sometimes manifested in different ways in children; for example, children may also be irritable, and fail to make expected weight gains.

Young children may feign illness, be hyperactive, cling to parents and refuse to go to school, and may express fears that their parents may die.

Older children may sulk, refuse to cooperate in family and social activities, get into trouble at school, and may abuse alcohol or drugs. They may give less attention to their appearance, become negativistic, and express feelings of not being understood. They may become restless, grouchy or aggressive.

This disorder may also be strictly seasonal, changing with the length of daylight (Seasonal Affective Disorder).

Anxiety Disorders

Among the anxiety disorders found are Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder, Panic Disorder with and without agoraphobia, Phobia, and other anxiety disorders.

Anxiety Disorders. Anxiety disorders refer to any of a number of exaggerated or inappropriate responses--affective (emotions), cognitive (thinking), motor (movement) or physiological (physical symptoms)--to the perception of external or internal danger. Children with this disorder have diffuse fears and worries that cannot be traced to specific problems or stresses. They worry excessively about examinations, potential injuries, friendships or group acceptance. Their anxiety may be expressed in various physiological symptoms (somatization) such as headaches, respiratory distress and other recurring problems.

Post-Traumatic Stress Disorder (P.T.S.D.). This disorder can occur at any age, including childhood. It follows a psychologically distressing event that is outside the range of usual human experience. These include such experiences as child abuse, natural disasters, accidents, witnessing homicide, war, and other violent or traumatic events.

Re-experiencing the traumatic event is common. Young children may repeat the event in their play. Other symptoms include avoiding thoughts or feelings about the event and avoiding activities or situations that remind them of the event. They may feel detached from other people, take less pleasure in previously enjoyed activities, have trouble sleeping, have nightmares, and have difficulty concentrating. They may have various physical symptoms such as stomach aches and headaches. Young children may lose recently acquired developmental skills such as toilet training or language skills.

Phobic Disorder. A phobic disorder is characterized by persistent irrational fears of a specific object, activity or situation (e.g., fear of heights, fear of airplanes, fear of crowds). Onset of phobias does not usually occur until late teens or early adulthood.

Obsessive Compulsive Disorder (O.C.D.) is a specific type of anxiety disorder that manifests itself through intrusive and persistent thoughts or impulses and compulsive behaviors or rituals that are performed in response to such thoughts. Individuals with O.C.D. most often know that their obsessions are senseless or exaggerated and that their compulsive behavior is either unnecessary or extreme, but they still feel overwhelming pressure to carry out the compulsion. Common compulsive behaviors may include excessive handwashing, putting an item of clothing on and then taking it off, placing things in a certain order, and hoarding objects so that nothing of value will be lost. For a person with O.C.D., obsessions and compulsions are very severe and they consume the person's time in such a way that interferes with social, academic and/or occupational functions. Compulsive eating, drinking, gambling, or sexual behaviors are not considered to be compulsive disorders because pleasure is obtained from these activities and an individual would not ordinarily wish to stop them, except for the secondary problems they may cause.

O.C.D. during childhood is unique among childhood disorders in that the symptoms are virtually identical to adult patients. The content of obsessions and compulsions among children and adolescents has not been found to differ from those of the adult disorder. The obsessions of children and adolescents usually involve concern over harmful events, death and contaminations. They may include checking and washing rituals, counting, and rigid ordering. Depressive symptoms are common, but in children and adolescents, these symptoms usually occur after the onset of obsessive-compulsive symptoms. O.C.D. can be difficult for parents and professionals to identify accurately and reliably. Although children may be aware of their emotional discomfort, they may have difficulty labeling or verbally communicating their feelings.

Eating Disorders

There are two classifications in the DSM-IV(R) for eating disorders. The first is **Feeding and Eating Disorders of Infancy or Early Childhood** which includes Pica Rumination Disorder and Feeding Disorder of Infancy or Early Childhood. The second is the adult **Eating Disorder** category which includes Anorexia Nervosa and Bulimia Nervosa which affect mostly adolescent girls.

Adolescents with **Anorexia Nervosa** have an intense fear of obesity and pursue thinness through self-imposed starvation. Individuals with this disorder have a distorted body image and an intense fear of gaining weight. Common signs of anorexia nervosa include: extremely low body weight; the loss of menstruation; excessive exercising; binge eating and purging; depressive symptoms; constipation; abnormally slow heart rate; low blood pressure; low body temperature; swelling of feet, hands, and sometimes nose and ears; dry skin and brittle nails; hair loss, and bizarre behaviors or thinking patterns, such as a preoccupation with and hoarding of food.

Bulimia Nervosa is characterized by episodic binge eating in which large quantities of food are consumed with a sense of urgency or loss of control and subsequent purging in which an individual may vomit, abuse laxatives, exercise excessively or follow a strict diet to counteract the effects of overeating. Girls with bulimia nervosa often experience extreme cravings for food, worry that they will not be able to stop overeating and are ashamed of their eating problem. Depression and self-critical thoughts may follow a binge. These girls also frequently abuse diet pills, amphetamines, and caffeine. Bulimia nervosa is different from anorexia in that there may be weight fluctuation and overemphasis on eating, but the weight loss that occurs with this disorder is not as severe as in anorexia nervosa. Symptoms include: irregular menstrual cycles or the loss of menstruation; muscle weakness or cramping; fatigue; dental problems; gastrointestinal problems; and intolerance of cold.

SECTION III: SPECIALISTS WHO PROVIDE DIAGNOSIS AND TREATMENT

Where Should I Take My Child for a Diagnosis?

It is difficult to know where to start when you suspect that your child may have an emotional disorder. Probably the safest and easiest place to begin is with the physician your child has been seeing on a regular basis--either a pediatrician, general or family practice physician.

When you make the appointment with the physician, explain that you would like some time to talk with the doctor privately. Prepare in advance for the appointment by gathering together all of the evidence you have about your child's problems. Make a list of your concerns so that you can discuss them item by item.

Your physician can do several things to start the diagnostic process. First of all, he or she can rule out any obvious physical diseases and conditions causing behavior problems. The doctor can then refer you to a neurologist or other medical specialist if further medical tests appear to be appropriate.

What Does a Neurologist Do?

A neurologist can perform various tests to determine whether the child's behavior problems are the result of brain or nerve damage. For example, a neurologist can conduct an E.E.G. (electroencephalogram), a test which measures electric impulses in the brain. By interpreting the results of this test, the neurologist can usually determine whether there has been brain damage. Almost all children with structural brain damage have abnormal E.E.G.'s, but an E.E.G. is not a perfect test. Some children with normal E.E.G.'s appear to show abnormalities when nothing is really wrong. The quality of an E.E.G. depends upon the competence of the technician making the recording and the skill of the physician who interprets the results.

What If the Problem Is Definitely Not Physical?

Once physical problems have been ruled out, your physician may refer you to a psychiatrist, psychologist or mental health clinic for further diagnosis. Most doctors who see many children encounter enough emotional disorders and make enough referrals that they become familiar with at least one or two individuals who work well with children who have an emotional disorder. However, if you live in a small community with few resources, it may be necessary for your physician to refer you to a larger community at some distance where the facilities and professional personnel are unfamiliar. In this case, both you and your physician may have to make extensive inquiries to find the right

program or person to work with your child. If your physician is not able or willing to make referral, contact your local mental health clinic and ask for assistance with locating appropriate services.

Culturally diverse families and those with non-traditional lifestyles need to be certain that professionals consider their children's unique cultures both in measurements of emotional disorders and in their treatment. Professionals need to consider the unique tendency of some cultures to present emotional disorders in ways possibly related to social and cultural factors.

Culturally appropriate adaptations of existing intelligence, child development, and psychological measures are increasingly available for culturally diverse children. Multiple procedures and tests should be used to ensure that the description selected for the child is the most accurate one. It is also necessary to assure that the child understands the tasks required for the test. It is recommended that testing should focus on describing behavior and abilities rather than on reporting one single score. The scoring of the tests, likewise, should take into account the ethnicity of the child. Tests should be used along with other information, and this is especially true for culturally diverse children.

How Should I Choose a Therapist for My Child?

There are a number of different types of therapists in the mental health field. It is absolutely critical that you investigate the credentials of the therapist you choose.

1. Contact the state licensure boards for social work, psychology and/or medicine to determine whether the therapist you are considering is licensed in your state. Be very skeptical of anyone who is not properly licensed;
2. Inquire of your medical insurance company whether your insurance covers the cost of seeing the type of therapist you are considering. If your insurance is an Health Managed Organization (HMO), check to see if the therapist is on the provider list and get a referral from your primary care provider before the first visit;
3. Ask the therapist for information about his or her training and background;
4. Be sure that your therapist's training provides him or her with the expertise to diagnose and treat your child's problems;
5. Do not hesitate to seek a second opinion if you are not satisfied with the first therapist; and
6. Change therapists if you or your child do not relate well to that individual.

What Kinds of Therapists Are Available?

Psychiatrist. Any licensed physician can practice psychiatry if he or she has an interest in that field. However, fully-trained psychiatrists have special training in the field, including an internship and residency in psychiatry, and then pass an examination which allows them to be board certified in psychiatry. Child psychiatry is a sub-specialty in psychiatry that requires additional training and experience.

Fully-trained psychiatrists can diagnose and treat emotional disorders. Since they are licensed physicians, psychiatrists are able to prescribe tranquilizers, sedatives, stimulants, and antidepressants which are helpful in treating some disorders. The only other type of mental health professional that can prescribe drugs is a nurse practitioner.

Psychoanalyst. Any individual can call him or herself a psychoanalyst. A psychoanalyst is someone who diagnoses and treats emotional disorders through an analysis of the facts of a patient's mental life.

If psychoanalysis seems like a desirable type of therapy for your child, look for a psychoanalyst who can provide evidence of specific training in the techniques of psychoanalysis. Preference should be given to psychiatrists who have chosen to specialize in psychoanalysis. With a psychiatrist you are more assured of the individual's considerable training.

Psychologist. Individuals who call themselves psychologists may actually come from a variety of different backgrounds. They may or may not have a college degree. Once again, it is important to look at the individual's credentials and see what they mean.

Clinical Psychologist. A clinical psychologist is an individual who has studied behavior and mental processes and is trained in the evaluation and treatment of emotional disorders. In most states, an individual must have a Ph.D. (a doctorate) in clinical psychology to be licensed in that field.

School Psychologist. A school psychologist has studied mental processes and behavior and is prepared to deal with behavior problems in the school setting. This individual is also trained to administer intelligence, aptitude and achievement tests and relate the results of these tests to school performance. School psychologists have to be licensed in most states and generally have at least a master's degree level training.

Psychotherapist. Psychotherapist simply means an individual who treats emotional disorders. It is such a general term that it is really meaningless without some additional indication of the individual's training and background.

Social Worker. The term social worker is sometimes used very loosely. In some states, individuals with no particular training or background in social work, but who perform social work functions, are called "social workers." In the mental health field, the types of individuals who are likely to be helpful as therapists are persons with training and licenses in the fields of clinical or psychiatric social work.

Clinical Social Worker. A clinical social worker is trained in social work techniques such as individual case work or group work, and holds an M.S.W. (master's) or Ph.D. or D.S.W. (doctorate) degree. Those social workers who have an L.C.S.W. after their names have a license from their state licensing board.

Psychiatric Social Worker. Some social workers specialize at the master's and/or doctorate level in working with psychiatric patients and their families. An individual with this level of training and background may be called a psychiatric social worker.

Nurse. Registered nurses (RNs) sometimes receive instruction in their nursing training in the care of patients who have emotional disorders or in emotional problems that accompany physical illnesses.

Psychiatric Nurse. Some nurses specialize at the master's degree level in the care of patients with emotional disorders.

Counselor. "Counselor" is another general term which really has no meaning, since individuals from a variety of backgrounds can call themselves counselors.

Family Counselor. "Family counselor" is also a nonspecific term. If a family counselor is also a licensed psychologist, psychiatrist, or social worker, then the individual may have the training and background to work with families. Be skeptical of family counselors who do not have degrees and licenses in mental health fields.

Guidance Counselor. A guidance counselor is an individual working in a school who is trained (at the bachelor or master's degree level) to do screening, evaluation and career and academic placement. This type of counselor may also do some limited personal counseling. In addition, the school guidance counselor often has primary responsibility for communications with the home, consultation during crisis situations, development of mental health programs and counseling in small group settings.

Christian Counselor. Some counselors claim to provide religiously-oriented therapy. If it is important to you that your child receive this type of therapy, first locate a therapist with the proper training and license. Then see if any of the therapists with credentials also provide a religious orientation in their therapy.

Indigenous Counselor. Choice of therapist is also dictated by culture; for example, some cultures make significant use of folk healers. The traditional healing practices of diverse cultural groups are being incorporated gradually into contemporary mental health treatment approaches. Culturally diverse families should assure that treatment is available for their children that combines respect for and an understanding of their culture, is presented in language their child understands, and is appropriate for their culture. A combination of the use of an indigenous counselor and another, more mainstream, therapist might be most beneficial to families, if the two service providers communicate effectively.

Should I Consider Cost When Choosing a Therapist?

Cost is, of course, something to think about when choosing a therapist. There is a wide range of fees which various types of therapists charge; however, in general, psychiatrists are the most expensive therapists, followed by psychologists and social workers. Individual therapy is more expensive than group therapy. Mental health clinics often have sliding fee scales based upon family income. School services for qualifying children are free.

Here are some things to consider about the cost of therapy:

1. Choose the type of therapist who can meet your child's needs. Psychiatrists are, in general, more expensive than other types of therapists, but they can provide some services which others cannot provide. If your child needs a psychiatrist, then cost has to be a secondary consideration.
2. If at all possible, choose a therapist whose fees are covered by your health insurance. Sometimes insurance companies will only pay if the referral to a therapist is made by a medical doctor before the first visit to the therapist. Be sure that you have such a referral. Many medical insurance companies have limited plans for psychological care. Be sure to read the fine print on your policy before you go too far or call your insurance carrier if you need clarification.
3. Choose the least expensive option that still gets the job done. Sometimes a child can be helped by having a few initial visits with a psychiatrist or psychologist, then follow-up visits with a social worker or school counselor. This combination of therapists would be much less expensive than seeing a psychiatrist several times.

SECTION IV: SERVICES AVAILABLE FOR CHILDREN

Core Values and Guiding Principles for Providing Services For Children and Youth

The Child and Adolescent Service System Program (CASSP), developed by the National Institute for Mental Health (NIMH) and the State Mental Health Representatives for Children and Youth (SMHRCY), gathered in 1983 to recommend new concepts and strategies for changing the service system for children with emotional disorders to improve the systems under which the most troubled children receive services. CASSP developed the following core values and principles to be used when developing a system of care for children.

Core Values for the System of Care. The system of care should be child-centered, with the needs of the child and family dictating the types and mix of services provided. The system of care should be community-based, with the locus of services as well as management and decision-making responsibility resting at the community level.

Guiding Principles for the System of Care:

1. Children with emotional disorders should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs;
2. Children with emotional disorders should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan;
3. Children with emotional disorders should receive services within the least restrictive, most normative environment that is clinically appropriate;
4. The families and surrogate families of children with emotional disorders should be full participants in all aspects of the planning and delivery of services;
5. Children with emotional disorders should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services;
6. Children with emotional disorders should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move throughout the system in accordance with their changing needs;

7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes;
8. Children with emotional disorders should be ensured smooth transitions to the adult service system as they reach maturity;
9. The rights of children with emotional disorders should be protected, and effective advocacy efforts for these children and youth should be promoted;
10. Children with emotional disorders should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics, and services should be sensitive and responsive to cultural differences and special needs. (Stroul, B. & Friedman, R. (1986), p. 7).

What Types of Services Are Available for Children with Emotional Disorders?

There is probably nowhere in the United States where a full range of services for children with emotional disorders exists. But parents of these children need to know what the possibilities are. Here is a set of ideal options ranging from the least restrictive (most natural setting) to the most restrictive setting.

Wraparound Services. Wraparound services focus on the needs of the child and his/her family. All those who provide care for the child, immediate family, friends, relatives and supportive service providers develop a plan of care according to the needs of the whole family. Besides offering the traditional services of therapy and family intervention, these services can also include respite care, transportation, after school care, personal in-home aide, or anything else the child and family needs in order to keep the child at home, and to support the child's development and appropriate community participation.

Home Intervention. The purpose of the home-based model of treatment is to provide intensive in-home crisis intervention to prevent placing children outside their homes away from their families. Such programs are directed toward managing crises and teaching families new ways of resolving problems to prevent future crises.

Successful home intervention programs have therapists available to families 24 hours a day for four to six weeks. During this period, families receive regular training sessions in their homes and may call on the therapists for help any time that a crisis arises.

Home-based providers are trained in behavior interventions, client-centered therapy, values clarification, problem solving, crisis intervention and assertiveness training. They

also may provide assistance with home management and budgeting skills, advocacy, and referral for legal, medical or social services.

Intensive home-based treatment facilitates an accurate assessment of the child and of the family's functioning. Home-based treatment also enables the therapist to model and shape new behaviors in the child's normal environment. Therapists can directly observe the treatment plan and revise it as necessary.

School-Based Services. Schools must provide appropriate special education for children who are identified as having serious emotional disorders and need special educational help. For children who qualify for special education, school staff and parents write an Individualized Education Program (IEP) that specifies the amount and type of special education the child requires, the related services the child may need, and the type of service that is suitable for providing the child's instruction. Related services may include psychotherapy if services are necessary for the child to benefit from his or her education. It is important to note that special education services are specifically educational in nature. While these educational services may be helpful to the child with emotional disorders, they often may only be a part of a child's complete treatment program.

Special education services must be provided at no cost to parents. The Individualized Education Program must be revised annually, with parents participating in the revision.

Community-Based Outpatient Treatment. Outpatient treatment usually means that the child lives at home and receives psychotherapy at a local mental health clinic or from private therapists. Sometimes psychotherapy is combined with a home intervention and/or a school-based special education program. Outpatient therapy may involve individual or group therapy, family therapy, or a combination of approaches.

Community-Based Day Treatment. Day treatment is the most intensive non-residential type of treatment. It has the advantage of keeping the child in the home, while bringing together a broad range of services designed to strengthen the child and improve family functioning. The specific features of day treatment programs vary from one program to another, but may include some or all of the following components:

- *special education*, generally in small classes with a strong emphasis on individualized instruction;
- *psychotherapy*, which may include both individual and group sessions;
- *family services*, which may include family psychotherapy, parent training, brief individual therapy with parents, assistance with specific tangible needs such as transportation, housing or medical attention;
- *vocational training*, particularly for adolescents;
- *crisis intervention*;
- *skill-building* with an emphasis on interpersonal and problem-solving skills and practical skills of everyday living;

- *behavior modification;*
- *recreation therapy, art therapy, and music therapy to aid social and emotional development; and*
- *drug and/or alcohol counseling.*

Children typically participate in a day treatment program for at least five hours a day, and lengths of stay are generally at least one school year and often more.

Many day treatment programs are physically located on a school site. In these cases, they often have a wing of their own that includes classrooms and office space. Other programs are run in mental health centers, other community agencies, or on the grounds of a hospital or private clinic.

Community-Based Residential Programs. Community-based residential programs involve the use of either group homes or therapeutic foster homes. This type of treatment assumes that there is a need to bring about a total change in the child's environment.

Foster-Home Placement. A foster home is in many ways a "natural" approach to providing treatment because it provides a family unit which is the customary developmental situation for a child. A therapeutic foster home is designed to provide additional components beyond the nurturing characteristics of a well-organized family. These additional components may include special training for the foster parents in behavior modification and crisis intervention, as well as access to psychotherapy, social work service, and other community resources. Therapeutic foster parents also often work in partnership with the child's family.

Group Home Placement. Placement in a group home is somewhat more restrictive than foster care, since the living situation is not totally "natural." Group homes provide family-style treatment in a more structured setting than the natural environment. Treatment usually involves a combination of evaluation, psychotherapy, use of behavior modification, peer interaction, and increasing self-government.

Residential Treatment Centers. Residential treatment centers provide round-the-clock treatment and care for children with emotional disorders who require continuous medication and/or supervision or relief from stresses in the environment, or whose families require relief from the stress of caring for them.

A number of residential treatment centers for children with severe emotional disorders have developed throughout the United States. Many of these facilities focus on a particular treatment philosophy. Generally, residential centers base their treatment on the premise that the child's total environment must be structured in a therapeutic way. Some emphasize particular diets and exercise regimes; others concentrate on behavior modification programs which function in the classrooms and in the dormitories as well;

still others use a patient-centered, "structured-permissiveness" approach. Some treatment centers are set up to deal specifically with alcohol and drug related problems.

While residential treatment centers have academic programs, a great deal of attention is directed to the child's emotional problems, regardless of whether they are associated with academic matters. Considerable time and effort is spent on group and individual therapy and therapeutic social activities. Many residential programs emphasize family participation; the degree to which parents receive support and encouragement varies across programs.

Residential Care/Hospital or Training School. Residential care in a hospital or training school tends to be the most restrictive type of treatment which comes about after other, less intrusive forms of treatment have been tried and have failed, or when a child has violated the law and been ordered by the court to a particular facility.

Psychiatric Hospital. A psychiatric hospital is a medical facility whose emphasis is on medical approaches to mental problems. Psychiatric hospitals tend to use medications and sometimes other physiological interventions. Hospitals which serve children must provide educational opportunities for them, but the primary mission of these facilities is not academics. Often a child or youth is placed in a hospital for emergency treatment or for medication management.

Training School. Training schools are generally a type of correction facility which is intended to serve delinquent youth. Depending on the level of financial support and degree of commitment from state government, some training schools offer psychotherapy, behavior modification programs and/or vocational training. In general, training schools are not desirable treatment facilities because they are usually underfunded and restricted to prison-like programs. All training schools are required by federal law to provide appropriate special education for children who qualify.

Are Support Services Available for Parents?

Parents of children with emotional and behavioral disorders are forming self-help support groups across the country. A parent from Parents Involved Network (PIN in Philadelphia) describes the functions of a support group this way:

Parents in self-help groups run by parents decide for themselves what they need to do. They organize or join a group with other parents, depend on one another for emotional support and practical guidance and, in most cases, unite with each other to challenge institutional and political decisions that harm or threaten their children.

Parents involved in mutual help groups or programs are in a unique position to empathize with the parents who call on them and are accessible in a way that professionals seldom are. Their concerns go beyond their own children and beyond the children of other parents who call on them for help. These parents almost always become interested in changing the institutions that provide services for their children and reforming the laws that govern these services.

An important point is that the passion that parents bring to advocacy for large-scale change springs from their own acute, painful experiences. Resourceful parents can make our policies, institutions, agencies and governments vibrant with respect for the power--and that's a big word--the power of parents. By depending on themselves, making demands on the system, fighting for our children, parents and professionals can work together to try to get services that meet the needs of the children and to make professionals responsive to parents and other family caregivers as well.

For information about a family group in your area, see Appendix.

Respite Services

Respite services involve the provision of short-term temporary care with the primary purpose of offering relief to the caregiver or caregivers of a person with disabilities. Respite care, then, is a service to the family, not only to the child who is the usual focus for services. Although there are currently few respite programs designed specifically for families of children with emotional disorders, the importance of respite care is being increasingly recognized by parents and service providers alike. For a number of years there have been respite services for families of the elderly and families of children with physical or developmental disabilities. Much of the information in this section is drawn from existing programs for those populations, but can be applied to the provision of respite care services to families of children with emotional or behavioral difficulties.

The immediate goal of respite care is to give parents or other caregivers a "break" from the continuous tasks and pressures of caring for a child with special needs, but there are equally important long-range goals. By having periods of relief, or knowing that they are available when needed, a family's level of stress can be significantly reduced. Therefore, the family's ability to care effectively for the child and cope with ongoing family issues is increased. Using respite services does not indicate that parents are unable to care for their child. Caring for a child with special needs is a very intense, high-pressure activity. Regularly scheduled and anticipated breaks can only enhance a parent's effectiveness.

Respite programs can take many forms. Care may be provided in the family's home, allowing caregivers the chance to get away, or may take place in the respite provider's home. In some cases, residential centers set aside a few beds for respite; in others, facilities such as community centers may be used for regular weekend or after-school

programs. Depending on program structure, respite care is typically provided for a few hours, a day or a weekend. Longer periods of care are offered by some programs, usually related to the severity of a client's disability or a special family situation.

Respite providers may be volunteers or may be paid, but in either case they should be trained in working with children who have emotional disorders as well as in first aid skills. Costs to parents vary from program to program. Services may be free, paid on a sliding fee scale, or at a set rate. In some cases, respite workers are paid directly by parents, with a central agency recruiting, training and matching the workers with families. Variations on this approach include subsidies to low-income families to help pay providers, and programs which allow parents to choose their own provider (perhaps a friend or relative) who is then paid by the agency.

Parent-run programs, sometimes called parent cooperatives or co-ops, have provided an innovative response to the need for respite services. Initiated by parents of children with various disabilities, some of these have expanded to include parent support groups, formal training, or even have become established agencies. There are several advantages to this approach. For example, parents can feel confident that their child is being cared for by someone who understands the nature of his or her needs and behaviors; there is a greater chance that the family and providers know each other, reducing concerns over a child being left with "strangers;" and parents are in control of funding and administrative mechanisms, assuring that the program truly meets the needs of families.

Even when parents do not directly control respite programs, their input remains crucial. Serving on advisory boards, participating in program and service evaluations, and interviewing potential providers are some of the ways that family members can influence the quality of respite services they will receive.

Although some communities do have respite services for families of children with emotional disabilities, most do not. Existing programs might be located through Information and Referral (I&R) systems (such as those provided by United Way), local mental health offices or child welfare agencies. If no programs are available, or existing programs do not appropriately address the child's needs, parents can take steps to have respite services developed. For example, programs serving children with physical or developmental disabilities may be interested in expanding to serve children with emotional problems. Parent demand and input into training and program structure are often required in order for them to do so. Other potential settings that may also be sources for qualified staff are local residential and day treatment programs serving children with emotional disorders. Community resources such as camps, schools, and summer or weekend activity programs can be encouraged to include staff trained to work with children who may have behavioral difficulties. Local vo-tech (vocational and technical) schools and community colleges often have child care or health care curricula that can be expanded to include training in working with special needs children.

New respite care programs can be initiated by forming parent cooperatives, or by working through agencies that provide other complementary services. Whether their goals are to expand existing programs or to implement new ones, parents will increase their effectiveness by involving funding sources, advocacy groups, agency administrators, and legislators.

When a program is located, parents will need to find out about cost, where care is provided (in-home, out-of-home), and what their responsibilities are regarding transportation and availability in case of emergency. Seeking information on training and supervision of providers is important to assure that quality care will be given to the child.

Respite providers should be flexible in meeting the family's needs and willing to be a part of the child's overall system of care by communicating with parents, teachers and other persons involved with the child.

The lack of respite services for families of children with emotional disorders highlights this as an important area for advocacy by parents. Parent demand was a key factor in the establishment of respite programs for caregivers of children with physical and developmental disabilities. It will also play a significant part in respite care becoming a regularly accessible support service to families of children with emotional disorders.

SECTION V: EXERCISES

Questions: The following exercises provide an opportunity for you to think about what you have read. The page numbers for each exercise indicate the section of the text on which the questions are based. Answers for the exercises are on page 57.

EXERCISE 1.1: Section I (p. 25)

Without referring to the text, fill in the blanks in the sentences below.

1. In the biological model, it is assumed that emotional disorders are caused by . . .

2. The biological model relies on two basic types of treatment:
 - a. _____
 - b. _____
3. In psychoanalysis, the causes of emotional disorders are assumed to be:

4. Behavioral therapists try to change behavior by providing:
 - a. _____
 - b. _____
5. In the ecological model, treatment involves:

EXERCISE 1.2: Section I (p. 25)

Define the following terms in your own words:

1. *Psychotherapy* means _____

2. *Play therapy* means _____

EXERCISE 2.1: Section 2 (pp. 27-33)

Match the terms (1 - 10) with their definitions (a - j) on the following page:

1. ____ Conduct Disorder
2. ____ Separation Anxiety Disorder
3. ____ Schizophrenic Disorders
4. ____ Pervasive Developmental Disorder
5. ____ Bipolar Disorder
6. ____ Oppositional Disorder
7. ____ Post-traumatic Stress Disorder
8. ____ Attention Deficit Disorder
9. ____ Anxiety Disorder
10. ____ Hyperactivity

- a. A condition characterized by a failure to remain attentive in situations where it is socially necessary to do so.
- b. A condition characterized by severely disorganized behavior and personality.
- c. Repetitive, persistent pattern of conduct that violates the rights of others.
- d. Aggressive behavior displayed by obstinateness and passivity.
- e. Separation anxiety brought about by being apart from familiar persons or territory.
- f. Excessive movement or activity.
- g. Distinct periods of elevated mood, usually accompanied by a major depressive episode.
- h. Extreme distortions or delays in the development of social behavior and language.
- i. A severe reaction to a psychologically distressing event.
- j. Exaggerated or inappropriate responses to perceived internal or external danger.

EXERCISE 3.1: Section 3 (pp. 35-39)

List the kinds of things each of these professionals contribute to a diagnosis of an emotional disorder:

1. Pediatricians

2. Neurologists

3. Clinical Psychologists

4. Psychiatrists

5. School Psychologists

EXERCISE 3.2: Section 3 (pp. 35-39)

On the following pages is a series of advertisements from the telephone book. List the therapists that appear to have appropriate credentials for working with children and adolescents with emotional disorders.

_____ -- _____	_____ -- _____
_____ -- _____	_____ -- _____

UPTOWN PSYCHOLOGICAL CLINIC

Dr. Michael Tillson

Licensed Clinical Psychologist

Marriage & Family Counseling

Divorce Mediation

Psychological Evaluations and Expert Legal Testimony

555-8916

PSYCHOLOGICAL SERVICES: CARING CHRISTIAN PROFESSIONALS

Silas Warne, Ph.D.

Frank Miles, Psy.D.

Licensed Clinical Psychologists

Sara A. Fine, Ph.D.

Malcolm Sves, M.A.

Clinical Associates

Individual, Marital, Family, Group Psychotherapy

Legal, Pastoral Consultation

No fee for initial consultation.

555-2154

NORTH CASCADES PSYCHOLOGICAL CLINIC

F. J. Frankel, Ph.D.

Cyril Wallace, Ph.D.

Nancy Knight, Ph.D.

Licensed Clinical Psychologists

Children, Adults, Adolescents, Couples

Psychotherapy

Marriage & Family Counseling

Eating Disorders

Neuropsychological Evaluations

555-0010

SAMPSON & SMITH

R. Sampson, M.A., M.C.

N. Smith, R.N., M.S.

Individual, Marital, Adult, Child, Family Counseling

555-6303

Karen Burns, M.S.W., A.C.S.W.

Licensed Clinical Social Worker

Practice of Psychotherapy

Individuals and Groups

Marital-Sexual Therapy

Insurance Accepted

555-6303

Ted Seeley

The Troubled Family

Individual, Marital & Family Therapy

Diagnosis & Treatment

Stress

555-1001

CITY CENTER PSYCHOLOGICAL SERVICES

Carter James, Ph.D.

Melvin Clement, Ph.D.

Licensed Clinical Psychologists

Individual & Family Psychotherapy

Sex Therapy

555-6526

Nick Able, Ed.D.
Licensed Psychologist
Individual, Family, & Marital Therapy
Psychological Evaluations
555-8502

RIVERSIDE FOUR
Dr. Nora Thomas
Clinical Psychology Services
555-1240

Mary North
Children & Adults
Individual and Family Therapy
Psychological Evaluations
Associated with the Eastside Clinic
555-5925

Fred Sims, Ph.D.
Clinical Psychologist
Individual, Marital, & Family Therapy
Children, Adolescents, Adults
Psychological Evaluations
Divorce Adjustment Therapy
555-0876

PSYCHOLOGICAL ASSOCIATES
Gary Brown, Ph.D.
Clinical Psychologist
Children+Adolescents+Adults
Psychological Evaluations & Psychotherapy
555-1224

NEW STRESS CENTER Hypnotherapy (weight control, bulimia, smoking,
agoraphobia, chronic, pain, migraine).
Stress
555-7725

EXERCISE 3.3: Section 3-(pp. 35-39)

After examining these advertisements for credentials, what are two additional steps you could take to investigate these therapists?

1. _____
2. _____

EXERCISE 4.1: Section 4 (pp. 42-45)

Arrange these types of services in order from the least restrictive (most normal) to the most restrictive:

- _____ Day Treatment
- _____ Outpatient Treatment
- _____ Training School
- _____ Residential Treatment Center
- _____ Home-Intervention
- _____ School-Based Services

EXERCISE 4.2: Section 2 (pp. 42-45)

Answer the following questions by circling True or False:

1. Home intervention services are usually long-term services, extending over one or more years. _____ True _____ False
2. Schools must provide psychotherapy as a related service for special education students who require it to benefit from their education.
 _____ True _____ False
3. Schools charge parents on a sliding scale basis for special education.
 _____ True _____ False
4. Day treatment is the most intensive non-residential type of treatment.
 _____ True _____ False

5. Therapeutic foster homes provide a more natural treatment option than group homes. ☐ True ☐ False
6. Residential treatment centers base their treatment on the premise that the child's total environment must be structured in a therapeutic way.
☐ True ☐ False
7. Psychiatric hospitals provide medical and therapeutic treatment, but they do not have to provide children with educational opportunities.
☐ True ☐ False
8. Many day treatment programs are physically located in schools.
☐ True ☐ False
9. Group homes provide family-style treatment in a more structured setting than the normal family environment. ☐ True ☐ False
10. Incarcerated children lose their right to special education.
☐ True ☐ False

ANSWERS

Exercise 1.1 (p. 49)

1. Physical problems such as genetic defects, poor nutrition, birth or accidental injury, physical illness, poisoning, or poor sleep habits.
2. (a.) Drugs, and (b.) Changing environmental conditions.
3. The result of psychological conflicts in the patient's past.
4. (a.) Positive reinforcement for desirable behavior, and (b.) ignoring (known as extinction) or negative reinforcement for undesirable behavior.
5. Intervention with both the individual and his or her environment.

Exercise 1.2 (p. 50)

1. *Psychotherapy* means the treatment of mental and emotional disorders.
2. *Play therapy* means a type of psychotherapy designed for children which involves using structured play situations to help a child gain insight into his or her behavior.

Exercise 2.1 (p. 50)

1. C
2. E
3. B
4. H
5. G
6. D
7. I
8. A
9. J
10. F

Exercise 3.1 (p. 51)

(Answers will vary.)

1. Knows patient's history. Knows family. Can rule out physical problems. Can refer parents to other medical professionals.
2. Can identify brain and/or nerve damage. Can give and evaluate an E.E.G.
3. Can evaluate and treat emotional disorders.
4. Can perform both mental and physical diagnostic tests. Can prescribe drugs and evaluate their effects.
5. Can administer intelligence, aptitude, and achievement tests. Can prescribe drugs and evaluate their effects.

Exercise 3.2 (pp. 52)

1. Dr. Michael Tillson, Clinical Psychologist
2. Silas Warne, Ph.D., Clinical Psychologist
Frank Miles, Psy.D., Clinical Psychologist
3. F. J. Frankel, Ph.D., Clinical Psychologist
Cyril Wallace, Ph.D., Clinical Psychologist
Nancy Knight, Ph.D., Clinical Psychologist
4. N. Smith, RN, Registered Nurse
5. Karen Burns, MSW, Clinical Social Worker
6. Unable to determine qualifications from listing.
7. Carter James, Ph.D., Clinical Psychologist
Melvin Clement, Ph.D., Clinical Psychologist
8. Nick Able, Ed.D.; Psychologist
9. Unable to determine qualifications from listing.
10. Unable to determine qualifications from listing.

11. Fred Sims, Ph.D., Clinical Psychologist
12. Gary Brown, Ph.D.; Clinical Psychologist
13. Unable to determine qualifications from listing.

Exercise 3.3 (p. 55)

1. Inquire with state licensure boards to see if these individuals hold current licenses in their fields (psychology, social work, counseling, psychiatric nursing).
2. Inquire about the types of training, schools attended, and professional association memberships of these individuals.

Exercise 4.1 (p. 55)

1. Home Intervention
2. School-Based Services
3. Outpatient Treatment
4. Day Treatment
5. Residential Treatment Center
6. Training School

Exercise 4.2 (pp. 55-56)

1. False
2. True
3. False
4. True
5. True
6. True
7. False
8. True
9. True
10. False

SECTION VI: REFERENCES

Several of the publications listed below have been important in shaping the thinking of mental health professionals. These materials are not "light" reading for lay persons, but they provide helpful insights into the background and terminology common to professionals.

The more recent publications listed reflect current research and outline contemporary trends in the mental health field.

Because of their specialized nature, some of these publications are not available in local book stores and libraries, so it may be necessary to use an interlibrary loan system or to consult a college, university or medical library.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders. (4th Ed. Revised)*. Washington, D.C.: American Psychiatric Association.

Anderson, C. M., Reiss, D.J. & Hogarty, G.E. (1986). *Schizophrenia in the family: A practitioner's guide to psycho-education and management*. New York: Guilford Press.

Andreasen, N.C. (1984). *The broken brain: The biological revolution in psychiatry*. New York: Harper & Row.

Byrne, K. (1989). *A parent's guide to anorexia and bulimia: Understanding self-starvers and binge/purgers*. New York: Henry Holt and Company, Inc.

Falloon, I., Boyd, J.L. & McGill, C.W. (1984). *Family care of schizophrenia*. New York: Guilford Press.

Goldfarb, L.A., Brotherson, M.J., Summers, J.A. & Turnbull, A.P. (1986). *Meeting the challenge of disability or chronic illness--A family guide*. New York: Paul H. Brookes.

Greenfield, J. (1973). *A child called Noah*. New York: Paperback Library.

Herzov, L., Berger, M. & Shaffer, D. (Eds.). (1978). *Aggression and antisocial behavior in childhood and adolescence*. London: Pergamon Press.

Ingersoll, B. (1988). *Your hyperactive child: A parent's guide to coping with attention deficit disorder*. New York: Doubleday.

- Kaplan, H.I. & Sadogah, B.J. (Eds.) (1985). *Comprehensive textbook of psychiatry II. (4th ed.)*. New York: Williams & Wilkins.
- Kauffman, J. (1989). *Characteristics of behavior disorders of children and youth, 4th Edition*. New York: Merrill Publishing Company.
- Lewis, D.O. (Ed.) (1981). *Vulnerabilities to delinquency*. New York: Spectrum.
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CHAPTER THREE

Understanding the Law

As you seek help for your child with an emotional or behavioral disorder, you gather information from a variety of sources. Much of that information comes from predictable fields like medicine and education, but you may be surprised to learn that it is also necessary for you to become familiar with the law as well.

To protect your rights as a parent and to secure an appropriate education for your child, you will need to know about several Federal Laws: Public Law 94-142, the original Education of All Handicapped Children Act of 1975; the Individuals with Disabilities Education Act, Public Law P.L. 101-476 (IDEA), of 1990; The Family Educational Rights and Privacy Act of 1974 (known as FERPA or the Buckley Amendment); Section 504 of the Rehabilitation Act of 1973; the Americans With Disabilities Act of 1990 (ADA), and Public Law 102-321 (Child Mental Health Services Program). In addition, you may need to be familiar with the juvenile justice system since there are sometimes conflicts in that system between parents' rights and the rights of the state.

As you become more familiar with the law, you will begin to see that it presents mixed blessings. The law can be a source of comfort and assistance to parents and other care providers whose children have emotional disorders because it guarantees that your child cannot be discriminated against on the basis of his or her disability. Further, your child must have access to the opportunities available to other children in the community. If the schools or other government agencies appear to be violating your child's rights, you have recourse through the law.

On the other hand, you may sometimes find your wishes as a parent conflict with certain regulations. For example, in some states it is necessary for parents to relinquish custody of their child so that the child can receive out-of-home treatment partially supported by the state.

Knowing your rights and understanding the legal system can be a tremendous help as you advocate for your child. This chapter provides some basic information about the law. But please regard the answers to the questions in this chapter as just a beginning. Because these materials are written for a widely divergent audience across the United States, it is not possible to give detailed information about specific laws in particular states. It is very important for you to go further and investigate the laws in your own state. In addition, the law is a dynamic force. As courts decide cases and as new legislation is enacted, the law continues to evolve. Do not assume that this chapter presents the last word on legal matters. For the most current and most specific information, consult a lawyer or an advocacy group in your state.

It may be a little difficult at first sorting through all the legal language, but as your understanding grows, you will find strength in some aspects of the law. It is reassuring to know that federal and state laws protect the rights of children with emotional disorders.

Finding out about those aspects of the law that are unclear or unfair to persons with emotional disorders will give you an agenda for reform in your community and state. Knowing the law can help you to obtain appropriate services for your child and assure that his or her dignity and personal worth are respected.

SECTION I: LABELS

What Do Labels Mean?

One of the most frustrating things about having children with emotional problems is that they often receive a variety of labels, depending upon which agency you consult. There is no question that the mental health field is complicated and that professionals within the field have widely divergent opinions about what the "correct" labels ought to be. Because of this widespread disagreement, it is difficult to make generalizations about the field and the labels that are used. The following is an attempt, however, to give you some insight into what is going on behind the scenes.

Labels are often the result of the basic attitude that a professional has toward emotional problems. Some professionals are most interested in the causes of emotional disorders, so the labels they use reflect that interest. Other professionals have no interest in causes, but are strictly concerned with outward behavior and how that can be changed. Still other professionals focus on possible physical origins for emotional problems. One child, seen by a variety of professionals, may acquire a series of labels reflecting the viewpoints of all the professionals involved. The trick for the parent is to try to make sure that the labels a child bears are: (1) truly descriptive in some way of the problem; and (2) lead to helpful treatment and/or education solutions.

There is nothing magic or particularly important about a label unless it leads to appropriate action for the child. Mislabeling a child, on the other hand, can be extremely detrimental because an incorrect label can lead to inappropriate treatment. To prevent mislabeling, you must be diligent in asking what the label means. If you are not satisfied that a label describes your child accurately, state your concern and seek other professional opinions.

What Are Some Common Labels and What Do They Mean?

Behavioral Disorder. Behaviors displayed over a long period of time which significantly deviate from socially acceptable norms for the individual's age and situation. Professionals using this term tend to be those more interested in changing an individual's behavior than in finding causes for the inappropriate behavior.

Brain-Injury. A condition in which an individual before, during, or after birth has received an injury to or suffered an infection of the brain. As a result of such organic impairment, there may be disorders that prevent or impede the normal learning process. This term is one that is used in the biological model.

Delinquency. A description applied to the behavior of a child who has been found by a court of law to have violated a law. A child with delinquent behavior may or may not also have serious emotional disorder.

Deviant Behavior. Behavior in an individual that breaks rules, often of a sexual nature.

Serious Emotional Disorder/Disability. Severe disorders of the emotional processes. This label is frequently used by those professionals who are interested in finding the causes for a person's emotional problems. "Emotional disorder" is the label used in P.L. 101-476 (IDEA), the federal law requiring education for children with disabilities. In recent years, the term "disorder" is used instead of "disturbance." IDEA also uses "people first" language, that is, speaking of "a child with an emotional disorder" instead of "an emotionally disordered child."

Mental Illness. A general term applied to the state of mind of individuals suffering from emotional problems. "Mental illness" is assumed to be the opposite of "mental health." Professionals who are interested in causes and cures for emotional problems use the term "mental illness."

Neurological Impairment. Damage to or some deficiency in the nervous system of the body; a biologically related term.

Sociopathology. A display of extreme hostility toward and disregard of society and for all organized segments of society.

Social Maladjustment. Difficulty dealing with society and groups of people.

SECTION II: FEDERAL STATUTORY AND CASE LAW

What Federal Laws Have Direct Bearing on the Rights of Children with Emotional Disorders?

The three most important pieces of legislation guaranteeing particular rights to children who have a seriously emotional disorder are the Family Educational Rights and Privacy Act of 1974 (FERPA), Section 504 of the Rehabilitation Act of 1973 and Public Law (P.L.) 101-476 (IDEA), The Individuals with Disabilities Education Act.

Additional legislation (P.L. 102-119, IDEA Amendment of 1991) meets the needs of infants and toddlers with disabilities and their families.

What Is FERPA?

This law, sometimes called the Buckley Amendment, guarantees the privacy of school records and ensures the parent's right to see, review and--if necessary-- amend, a child's school records. FERPA applies to all children in school, not only to children with disabilities.

What Is Section 504?

Section 504 is a part of the Rehabilitation Act of 1973. That section provides that no program or activity receiving federal funds can exclude, deny benefits to, or discriminate against any person on the basis of disability. Since most schools receive federal funds, they are bound by the provisions of Section 504. Regulations attached to Section 504 apply to all states. Complaints charging discrimination can be lodged with the Office of Civil Rights. (See Appendix for information concerning contacting the Office of Civil Rights.)

What Is the Individuals with Disabilities Education Act (IDEA)?

The Individuals with Disabilities Act (IDEA) was formerly known as Public Law 94-142 (Education of Handicapped Act). Although its name changed in 1990 to IDEA (and it was re-authorized as Public Law 101-476), Part B of the law is still popularly referred to as Public Law 94-142. Its name change reflects a move away from the word "handicapped," which carries negative connotations, to the more neutral word "disabilities."

Part H of the IDEA is entitled "Infants and Toddlers with Disabilities." It is popularly referred to either as the "early intervention law" or as Public Law 99-457 (Part H) (Education of the Handicapped Act Amendments of 1986).

Under the IDEA, "a free and appropriate public education" is guaranteed to all children with disabilities. Under this law, schools are required to seek to identify all children with disabilities in their area. Further, once children are identified as having a disabling condition, they must receive an appropriate education at no expense to their parents or legal guardians, regardless of the nature or severity of the disabling condition.

What Is P.L.102-119?

In 1991 this amendment to IDEA was made to address the needs of infants and toddlers and their families. It requires the development of comprehensive, coordinated service system programs to meet the needs of these families. Included is the provision of a service coordinator (formerly called a case manager) to assure that services are provided in a family-centered, coordinated, and effective manner.

To What Ages Does P.L. 101-476 (IDEA) Apply?

The original IDEA (formerly known as the Education for All Handicapped Children Act) passed in 1975 applied to children of school age. In October 1986, the legislation was amended and the mandate for special education services was extended down to age 3 with the option of further extension to birth. After school year 1990-91, states serving preschool children with disabilities from ages 3-5 must serve all qualifying children or relinquish their rights to federal funds for preschool children with disabilities.

Educational services cease at different ages depending upon the individual state's legislation. Some states serve children until they reach the age of 18, while others extend services to age 20, 21 or 22.

What Is an Appropriate Education?

P.L. 101-476 (IDEA) defines appropriate education as an individualized education program specially designed to meet the unique needs of each child with a disability. In addition, the child must have access to a full range of services, called "related services" which may be necessary to help the child benefit from his or her education. The law specifies thirteen possibilities for related services:

1. Audiology;
2. Counseling services;

3. Early assessment and identification;
4. Medical services (for diagnosis of a disability);
5. Occupational therapy;
6. Parent counseling and training;
7. Physical therapy;
8. Psychological services;
9. Recreation;
10. School health services;
11. Social work services in schools;
12. Speech pathology;
13. Transportation;
14. Transition Services; and
15. Assistive Technology

Any of these services, or others not mentioned, must be provided if they are necessary for the child to benefit from his or her education. Each child who has qualified for special education services due to a disability must have a written Individualized Education Plan (I.E.P.).

Infants and Toddlers have additional requirements for services to meet their needs and the needs of their families. Added to the above list of related services are:

1. Service coordination;
2. Family training;
3. Home visits;
4. Nutritional services;
5. Vision services; and
6. Necessary transportation and related services that enable an infant or toddler and his or her family to receive early intervention services.

Infants and Toddlers receive an Individualized Family Support Plan (I.F.S.P.), reflecting the role of the family in the care and education of the young child with a disability.

Do Children with Emotional Disorders Qualify for Services under P.L. 101-476 (IDEA)?

"Serious emotional disorder" is one of the disabling conditions recognized under P.L. 101-476 (IDEA). The federal definition of "serious emotional disorder" is:

...A condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:

(A) An inability to learn which cannot be explained by intellectual, sensory, or health factors;

- (B) *An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;*
- (C) *Inappropriate types of behavior or feelings under normal circumstances;*
- (D) *A general pervasive mood of unhappiness or depression;*
- (E) *A tendency to develop physical symptoms or fears associated with personal or school problems.*

Under the federal definition, the term includes children who have schizophrenia but does not include children who exhibit socially maladjusted behavior, unless it is determined that they are also have a serious emotional disorder. Children with autism are classified under "other health impairment," not "emotional disorders," although they may receive educational services similar to children with emotional or behavioral problems.

Individual states have further refined the definition of "serious emotional disorder" and may use other terminology to identify the same category. It is important to check with your state educational agency or your local school district to see how "emotional disorder" is defined in your state.

Why Are Students with "Social Maladjustment" Excluded from P.L. 101-476 (IDEA)?

The definition of "serious emotional disorder" is loaded with subjective, value-laden words that do not have precise meanings. Making distinctions between a child who exhibits "social maladjustment" and one who has a "serious emotional disorder" is very difficult. The general intent of the definition is to point out that there is a difference in degree between the individual who displays contrary behavior, who is a nonconformist, or who chooses to behave differently, and an individual who suffers to a "marked degree" from an inability to relate to others, extreme depression, withdrawal and social isolation, or disoriented or psychotic behavior.

Social maladjustment is characterized by the inability to tolerate structure, marked dislike of school, behavior beyond the control of family caregivers, drug abuse, poor tolerance of frustration, excessive need for immediate gratification, disregard or hostility towards authority figures, lack of social judgment, inconsistent performance, positive behavior response when strong structure is instituted and lack of pervasiveness of disorder.

A teenager with a serious emotional disorder may have some of these same characteristics, but the characteristics would be "intense and pervasive" and would be manifested to a marked degree and over a long period of time.

Determining whether a child has a social maladjustment or a serious emotional disorder requires expert professional judgment and careful analysis and documentation. It is important, as a parent, for you to know what steps the professionals are taking to document your child's proposed label and whether they are using appropriate standards.

What Is the Difference Between a Serious Emotional Disorder and a Behavioral Disorder?

The terms "serious emotional disorder" and "behavioral disorder" are often used interchangeably to refer to the same population. Some have suggested that "behavioral disorder" is a more neutral term, carrying with it less of a stigma. Others suggest that "serious emotional disorder" is a more descriptive term because it identifies a more severe problem. The U. S. Department of Education commissioned a study of the two terms with a view to changing the terminology in P.L. 101-476 (IDEA) from "serious emotional disorder" to "behavioral disorder." This study concluded that changing the terminology would not solve the overall problem of making the definition more precise or more useable.

The current federal regulations for P.L. 101-476 (IDEA) allow states a great deal of freedom to determine how severe a student's problems must be for the student to be eligible to receive services. This latitude contributes to major inconsistencies in identification of students with emotional disorders from state to state.

Does a Student Who Is Diagnosed as Having a Mental Illness by a Physician Qualify for Services under P.L. 101-476 (IDEA)?

A physician's diagnosis alone does not qualify a student for services under P.L. 101-476 (IDEA). Because P.L. 101-476 (IDEA) is an education law, services are provided to children under this law only if their disability interferes with their ability to do school work. To qualify a child for services, it must be demonstrated that he or she has a disability and that the disability interferes with the student's ability to benefit from education. A doctor's diagnosis must be given due consideration in deciding whether the child's disability impacts him/her in an educational sense, but other factors must be considered as well.

Some children with emotional problems continue to do well academically. Though they are in need of counseling or other types of help, they may not require those services to benefit from their education. On the other hand, children do not have to be failing to show that their disability interferes with their ability to benefit from this educational program, and that they need special programming and intervention.

P.L. 101-476 (IDEA) is not intended to provide treatment for children. Instead, it is a guarantee that those children whose disabilities interfere with their education receive appropriate services to help them benefit from schooling. The extent to which school districts and special educational districts pay for treatment as a part of "related services" varies widely across the country. New case law is developed each time lawsuits related to special education are decided.

Is Psychotherapy a Related Service?

This is a highly controversial question which has generated considerable legal action. Part of the problem is defining psychotherapy. If psychotherapy is defined narrowly, then provision of psychotherapy may imply having the services of a psychiatrist. Since psychiatrists are medical doctors, psychotherapy in this sense can be considered a medical service and thus not an allowable related service, except for diagnostic purposes, under P.L. 101-476 (IDEA).

If, on the other hand, psychotherapy is defined more broadly to mean treatment for psychological problems, then it could be a related service provided by nonmedical professional staff like a school psychologist, guidance counselor or social worker.

Thus, it appears that psychotherapy can be a related service if a child requires such therapy to benefit from his or her education, if such service can be provided by nonmedical professional staff, and if such therapy is a support to, rather than the main element of, a child's special education program.

What Rights Do Students Have in the Special Education Process?

According to Section 504 and the Individuals with Disabilities Education Act and its regulations, children with a disability have the right to:

1. A free and appropriate public education (FAPE) from the age of 6 through 18. (Many states also provide services to preschoolers and to students past the age of 18);
2. Access to the same variety of programs and services that children without disabilities enjoy, including non-academic subjects and extra-curricular activities;
3. Placement in the least restrictive learning environment, as much as possible at the same school they would attend if they did not have a disability;
4. The availability of an appropriate learning setting if attending a local public school is not possible;

5. The appointment of a person to act as a parent surrogate, and to participate in assessment and Individualized Education Program meetings with the school if parents are unavailable or if the child is a ward of the state;
6. Participation in the writing of their own Individualized Education Programs;
7. Placement outside the school district in another public school or private school at public expense if local schools do not have an appropriate or available program;
8. Testing for purposes of assessment and placement that is free of racial or cultural discrimination;
9. An annual review of placement based on an I.E.P.;
10. Remain in present placement during administrative or judicial proceedings, or the right to attend a public school if the complaint involves an application for admission to public school; and
11. Privacy and confidentiality of all personal records.

What Rights Do Parents Have in the Special Education Process?

Under the P.L. 101-476 (IDEA), as parents of a child with a disability, you have the right to:

1. Participate in the annual review of your child's Individualized Education Program (I.E.P.) or Individualized Family Service Plan (I.F.S.P.);
2. Agree to a time and place for those meetings;
3. Instruct the local school agency to hold those meetings in your primary language, and to make special arrangements for any disability you may have, so that you can understand the proceedings (example: providing an interpreter for parents who have a hearing impairment);
4. Give your consent before an assessment is conducted;
5. Receive a copy of the assessment report;

6. Seek an independent assessment of your child at public expense if you find the school's assessment inappropriate. The school may request a hearing to decide the appropriateness of its assessment. If the ruling is in the school's favor, you still have the right to submit an independent assessment which must be considered but which is conducted at your expense;
7. Give voluntary written consent to any activities proposed for your child;
8. Have written notice of any proposed change or the school's refusal to make a change in identification, assessment, or placement of your child;
9. Attend and comment at the annual public hearing which must be publicized and held prior to adoption of the state plan for special education;
10. Review and, if necessary, question your child's records in accordance with the Family Educational Rights and Privacy Act of 1974;
11. Disagree and refuse consent on the following issues:
 - a. Correcting or changing information in your child's files;
 - b. Evaluating your child;
 - c. Placing your child in a special education program;
 - d. Obtaining additional information from an outside source about your child;
 - e. Giving information from the school to another person about your child;
 - f. Changing the special program placement of your child; and
 - g. Removing your child from the special education program;
12. Request a due process hearing on any proposal to initiate or change:
 - a. the identification, assessment, or placement of your child;
 - b. the provision of a free appropriate public education for your child; or
 - c. the agency's refusal to do these things.

(To request a hearing, you must write a letter to your local school explaining your concerns and your desire for a hearing.)

13. If the due process hearing does not produce a favorable result, you have the right to appeal to the next administrative level (state education agency) and/or to initiate civil action in the courts; and
14. Expect that information about your child will be kept private. No one may see your child's special education records unless you give your permission in writing. The only people who do not need that permission in writing are teachers and other

school personnel who are planning your child's educational program or monitoring compliance with P.L. 101-476 (IDEA).

Can Family Members Be Required to Receive Counseling in Order for a Child to Receive Special Education?

Families whose children have emotional disorders cannot be required by the school district to undergo counseling. The child who qualifies for special education is entitled to an appropriate, individualized educational program without regard to what the child's caregivers do or do not do. Parents or guardians must be included in the development of the Individualized Education Program (I.E.P.), but they cannot be required to participate or to do anything else which is not required of other families with children in school. On a voluntary basis, family members may wish to seek counseling or to coordinate family counseling with the special education program at school.

From a Legal Standpoint, How Important Is the Individualized Education Program?

In the years since the passage of the Individuals with Disabilities Education Act the courts have held school districts accountable for providing the services and the type of placement indicated in the Individualized Education Program. School districts must make good faith efforts to implement the I.E.P. To ensure that the I.E.P. contains all that it should, the child's care providers must monitor the document carefully and must visit the classroom to make sure that the I.E.P. is being implemented as planned.

What Should Be in an Individualized Education Program?

An I.E.P. must include:

1. A statement of the child's current level of educational performance;
2. Annual goals;
3. Short-term objectives to reach the annual goals;
4. A description of the services to be provided;
5. An explanation of the extent to which the child will participate in regular educational programs;
6. The projected date to begin services and the anticipated duration of services; and
7. Criteria for determining, at least annually, whether goals and objectives have been achieved.

What Does "Least Restrictive Environment" Mean?

Services to the child with a disability must be offered in a setting which deviates the least from the regular program and which is still appropriate for the child. In preparing P.L. 101-476 (IDEA), Congress recognized the need for children with disabilities to be included in normal environments as much as possible. Therefore, the law requires that children with disabilities be educated to the maximum extent possible with non-disabled peers, and if at all possible, in their neighborhood school.

What Is Mainstreaming and What Is Inclusion?

There are two approaches to accommodate children with disabilities within school settings, mainstreaming and inclusion. Mainstreaming provides children with disabilities the opportunity to be a member of a special education class and attend regular classes for particular subjects. Children who are mainstreamed receive special support services in their special education setting. Children in inclusive classrooms receive all their support services within their regular classroom. Inclusion refers to the educational option for all students to be educated in age-appropriate regular classes in their neighborhood school. All necessary supports are provided for students and educators to ensure meaningful participation in the total school community.

How Does Least Restrictive Environment Differ from Mainstreaming and Inclusion?

Much confusion has arisen because the concept of least restrictive environment (L.R.E.) is sometimes equated with mainstreaming or inclusion. Neither inclusion or mainstreaming are actually mentioned in P.L. 101-476 (IDEA). The law does not require that every child with a disability be placed in the regular classroom. Rather, the law says that to avoid placing children in settings that are too restrictive, school districts must provide a full range of options to meet the varying needs of children with special needs. The placement in special education must be determined for each child on an individual basis and according to that child's needs.

When determining an appropriate placement, prime consideration must be given to placing the child in the setting which is closest to normal and which still meets the child's needs. For some children the least restrictive environment will be the regular classroom. For others L.R.E. may mean the resource room or a self-contained class. The point is that each child's case must be considered individually, and each child must be placed in an environment that is the least restrictive and most socially integrated that he or she can manage.

What Should Parents Do Who Think Their Child's Special Education Program Is Inadequate?

If you think that your child's program is inadequate, ask for an I.E.P. meeting to discuss the program and come up with a plan to remedy deficiencies. However, do remember that P.L. 101-476 (IDEA) guarantees an appropriate educational program, not the best possible one. You and the school district may disagree about whether the program being offered is appropriate. You may think that the school district is doing too little. School officials may contend that you are asking for too much. If you cannot settle your disagreement on an informal basis or through mediation, it may be necessary to go to a due process hearing.

What Is a Due Process Hearing?

A due process hearing is a formal legal proceeding presided over by an impartial hearing officer who listens to both sides of the dispute and renders a decision based upon the law. To request a due process hearing, submit your request and a written copy of your concerns to the school board and superintendent of your school district.

Who Pays When There Is a Due Process Hearing or When a Special Education Case Goes to Court?

Due process hearings are held at public expense. In a court action, the judge may award the cost of reasonable attorney's fees to parents of a child with a disability if they are the prevailing parties in the case.

SECTION III: SCHOOL AND TREATMENT PROBLEMS

May a Student with a Serious Emotional Disorder Be Excluded from School?

P.L. 101-476 (IDEA) clearly forbids the exclusion of children with disabilities from school. Regardless of the type or severity of disorder, children cannot be denied access to a free appropriate public education because of their special needs. In the case of disruptive students, the courts have said that schools may not totally exclude students whose disabilities have caused them to be disruptive. Rather, schools have the duty to place students with behavioral disorders appropriately so that their behaviors can be properly controlled. During the time that school officials are seeking suitable placements, schools may refuse to admit students who may be a danger to themselves or others.

Thus, for a short period of time, schools may deny a child entrance while arrangements are being made for a suitable placement. However, such a child may not be denied admission to a school program and the child's care providers must give their consent before a child is placed. In addition, the child's care providers have the right to protest undue delay or to disagree with the placement decision.

Can a Special Education Student Be Suspended or Expelled from School?

The discipline of students with disabilities has emerged as one of the more controversial issues since the implementation of the first education law for children with disabilities in 1975. Neither the Act nor its regulations addresses the discipline issue directly, but many provisions have implications for the application of disciplinary policies to children with disabilities. In general, as the courts have interpreted the act, they have upheld the authority of school officials to maintain order and discipline, while at the same time saying that the law cannot be circumvented through disciplinary policies. A balance has to be struck between the need of school authorities to maintain discipline and the rights of students with serious emotional disorders to obtain an appropriate education.

Students with disabilities are neither immune from a school's disciplinary process nor are they entitled to participate in programs when their behavior impairs the education of other children in the program. Students with disabilities may be given minor disciplinary sanctions including a short-term suspension (up to 10 days in one school year). School officials also may take whatever emergency action is necessary to restore order to a school following a disciplinary disruption.

If a student is suspended from school on an emergency basis because of dangerous or extremely disruptive behavior, alternative appropriate education must be made available

to the student until a suitable educational environment is found. It is not permissible to place a student on indefinite suspension while a suitable alternative placement is being located. Indefinite suspension could have the effect of excluding the student from the educational process, and therefore such suspension would be prohibited by the Individuals with Disabilities Education Act.

Parents and the student must be given notice of the charges for which suspension is the disciplinary action, and the student must be afforded a hearing on the charges. Further, suspension should trigger a complete review of the student's Individualized Education Program to determine if the student's current placement is appropriate.

The Individuals with Disabilities Education Act has been interpreted to provide that schools cannot expel students whose disabilities caused them to be disruptive. Rather, schools have the duty to place students appropriately, so that their behavior can be managed. However, the Act does not prohibit all expulsions of disruptive children with disabilities. It only prohibits expulsion of those students who are disruptive because of their disabilities. Whether a child with a disability may be expelled because of his disruptive behavior depends on the reason for the disruptive behavior. If the I.E.P. team determines that the cause of the misbehavior is not the child's disorder and there is just cause for disciplinary action, then the child can be expelled.

Before a student with a disorder can be expelled, the child's I.E.P. team must determine whether the student's misconduct bears a relationship to his/her disabling condition. For a disability to be considered the cause of the misbehavior, the link between the disability and the behavior must be direct.

In addition, if the school system is considering expelling a student with a disability, he or she must be afforded the following due process rights:

1. notice of charges;
2. notification of parents or legal guardians;
3. legal counsel;
4. the opportunity to confront and cross-examine witnesses and accusers;
5. a transcript of the proceedings; and
6. the opportunity to appeal.

Expulsion is considered a change in placement. Thus, the decision to expel, since it is a change in placement, requires the calling of an I.E.P. meeting and a decision from the team about a more suitable educational placement for the student. If due process procedures are followed, a student with a disability may be expelled for just cause, but expulsion of that student cannot lead to a complete cessation of education services.

Does a Student with a Drug or Alcohol Problem Qualify for Special Education?

Drug addiction and chemical dependency are not mentioned as disabling conditions under P.L. 101-476 (IDEA). In general, students with these types of problems have not been served in special education unless they meet the criteria for one of the disabling conditions listed in IDEA. However, they may qualify for special considerations under Section 504.

Some school districts have served chemically dependent students when they are in treatment by placing them in the category of "other health impaired." Education must be provided to all children, regardless of their residential setting.

Parents of a child with chemical or alcohol dependency need to determine the policies for their state. This can be done by contacting the National Association of Protection and Advocacy Systems and asking for their state Protection and Advocacy phone number. (See Appendix.) Some of the questions to ask are:

Does the school district provide special services for the chemically dependent student who is:

1. Homebound and under medical treatment or doctor's orders;
2. Residing in a residential treatment center;
3. Placed out-of-district at a residential home, school or treatment center for the chemically dependent; or
4. An outpatient at a treatment center?

If homebound services are provided, how long do they last?

When a student returns from treatment, what services are provided to help him or her catch up with academic work?

Does the school district have any obligation to provide remedial services?

Must School Districts Pay for Residential Treatment for Students with Emotional Disorders?

School districts are obligated to provide appropriate educational programs for qualifying special education students. If the school district can serve a child with an emotional disorder in a nonresidential school program which is appropriate for the child, then the school district is not obligated to pay for a residential program simply because the parents would prefer that program.

The question becomes whether the program the school district is offering is, in fact, appropriate to meet the child's needs. If there is disagreement about the appropriateness of the program, the matter can be taken to a due process hearing. If the hearings officer rules that the school program is not appropriate and that a residential placement would be appropriate, then the school must bear the cost of that placement.

If parents make the decision on their own to place a child in a residential treatment program, the school district cannot be held responsible for the cost of that placement unless it can be demonstrated that the school district had no suitable placement. Again, the determination about whether the school district has a suitable placement may have to be made in a due process hearing. P.L. 101-476 (IDEA) provides:

Disagreements between a parent and a public agency regarding the availability of a program appropriate for the child, and the question of financial responsibility, are subject to the due process procedure.

Must Parents Give up Custody of Their Child in Order for the Child to Receive Publicly Funded Out-Of-Home Care?

Some children require out-of-home treatment for their mental, emotional or behavioral disabilities. This may mean placement in a therapeutic foster home, group or other residential child care setting. Obtaining such treatment can present an enormous problem for families due to the high costs involved. Very few families have the financial resources to pay for even a short stay in a residential center. Some families do have health insurance that will cover part, but seldom all, of the cost of placement in an out-of-home setting. Families with health insurance may also quickly exhaust the lifetime limits of their policies in funding the out-of-home care their children require.

Many state child welfare agencies will not fund the out-of-home placement expenses of a child with a disability unless the parents either (1) "voluntarily" relinquish custody of their child to the state child welfare agency or (2) have their child appear in juvenile court and be declared or "adjudicated" a "ward of the court."

Treatment providers as well as state child welfare authorities often explain that relinquishment is required by the federal Adoption Assistance and Child Welfare Act of 1980 (also known as Public Law 96-272 or Title IV-E of the Social Security Act). In fact, such relinquishment is not required by federal law. Title IV-E provides that states may receive federal dollars (reimbursement) for out-of-home foster care maintenance for children who have been voluntarily placed with the state.

A few states do not require families to transfer legal custody of their children to a state agency in order to receive public funding for the out-of-home treatment expenses. As of

Fall 1994 these states include: Iowa, Minnesota, Oregon, Pennsylvania, Tennessee, and Wisconsin.

What Does "Adjudicated" Mean?

In this context, "adjudicated" means coming under the protection or guardianship of the court. Court guardianship can be continued for an indefinite period of time and can be useful in obtaining services for a child who has an emotional disorder. Although children's courts usually rely on recommendations or changes suggested by caseworkers or state agencies, the courts can also implement therapeutic and corrective actions of their own. Courts may stipulate attendance in a vocational or trade school, treatment by psychotherapy, the assignment of a caseworker to work with families, placement in a foster home or children's residential treatment center, or commitment to a psychiatric hospital or correctional institution.

When a child has been adjudicated, there is no question that parents lose decision-making powers on behalf of the child. Parents may contest court decisions, but the courts usually have the support of other legal agencies and often may impose even more stringent consequences in reviewing their decisions.

Under What Circumstances Do Parents Lose Custody?

Parents can lose custody of their children if it is demonstrated that those children suffer from abuse and neglect. These circumstances must be distinguished from the situation in which parents "voluntarily" relinquish custody or have their children declared wards of the court in order to access publicly funded out-of-home treatment services. All 50 states have "protective services" agencies whose responsibility is to deal with cases of neglect and abuse of children. Protective services staff investigate reports of child abuse and advise the courts when there is evidence that abuse exists. Usually parents are offered an opportunity to remedy the abuse situation. If the parent refuses to cooperate or the abusive situation is not redeemable or is immediately dangerous, the abused child can be removed from the home and legal proceedings can be initiated against the parents.

In child abuse cases, the judge has the power to interpret such vague conditions as "proper care" and situations "prejudicial to the child's well-being." In general, courts have agreed that a parent has a right to live as he or she pleases within broad limits; that is, the parent need not have a job, be married to the person he or she lives with, or spend his/her money on the family. Courts have decreed that the rights of each citizen include the freedom to marry, establish a home, bring up children, and enjoy privacy. However, the parent does not have the right to deprive children of the necessities of life, abuse them physically or emotionally or deny them treatment they require.

The federal Child Abuse and Treatment Act, (P.L. 93-247) defines child abuse and neglect as:

any physical or mental injury, sexual abuse, negligent treatment or maltreatment of a child under the age of 18 by a person who is responsible for the child's welfare.

If there is evidence of child abuse and neglect and parents refuse to comply with efforts to improve the situation, the parents may lose custody of their children. Under these circumstances, the courts assume responsibility for assuring that the children receive treatment for their abuse and neglect as well as foster or residential care.

When a Child Is Sent to a Correctional Facility, What Rights Does the Child Have?

The answer to this question varies somewhat from state to state. However, because P.L. 101-476 (IDEA) is a federal law its provisions apply to children throughout the United States. Any child who is of school age and who is determined to have a disability must receive a free appropriate public education, regardless of whether that child is in a correctional facility. So a child in a state correctional facility who qualifies for special education should receive that education during his or her stay at the training school. If the child is a ward of the state (which is often the case in these situations), a surrogate parent can be appointed to represent his or her interests in the special education process. Families who wish to be involved also may be included.

Access to Financial Help and Services

Supplemental Security Income (S.S.I.). In 1990 the *Zebley v. Sullivan* decision of the United States Supreme Court found that the Social Security Administration's regulations for evaluating disabilities were more restrictive for children than for adults. As a result, new regulations were announced to determine whether a child has a disability for purposes of Supplemental Security Income benefits. Under the new regulations a child may be found to have a disability: (1) if his or her condition appears in the Administration's listing of impairments; (2) or if the child has a condition as functionally or medically as serious as one of the listed impairments; or (3) if the impairment prevents a child from performing age-appropriate activities. The third criterion requires an individualized, functional analysis of the impact of an impairment on children who have filed disability claims. Children who were denied S.S.I. after January 1, 1980, may, if they meet eligibility standards, receive S.S.I. payments as well as benefits back to the initial date the child applied for benefits.

Secondly, in December 1990 the Social Security Administration revised and expanded its list of childhood mental impairments. New additions to the children's list include attention deficit hyperactivity disorder, personality disorders; somatoform, eating, and tic disorders; anxiety disorders; psychoactive substance dependence disorders; autistic disorder and other pervasive developmental disorders; and developmental and emotional disorders of newborn and younger infants (birth to age one). Children who have one of these listed conditions have a disability for purposes of eligibility for Supplemental Security Income (S.S.I.).

Services for Children Eligible for Medicaid. Children who are eligible for Medicaid have a range of services available. Federal law mandates that all children receiving Medicaid are eligible for Early and Periodic Screening, Diagnosis, and Treatment (E.P.S.D.T.) with a referral from a medical professional for both medical and mental health purposes. All children and youth participating in the E.P.S.D.T. program must receive periodic hearing, vision, and dental screening services at regular intervals. Children who do not pass the screening examinations are referred for assessment and diagnosis. States must provide all necessary treatment services allowed under federal Medicaid law to treat physical and mental illnesses or other conditions identified by an examination even if these services are not offered to other Medicaid recipients under state law.

Sources of Information about Mental Health Issues

See Appendix for addresses and phone numbers of organizations that are concerned with children's mental health issues.

SECTION IV: EXERCISES

Questions: The following exercises provide an opportunity for you to think about what you have read. The page numbers for each exercise indicate the section of the text on which the questions are based. Answers for the exercises are on page 7.

EXERCISE 1.1: Section I (pp. 61-62)

Match the following terms with the definitions listed below.

- | | |
|--------------------------|--------------------------------|
| ___ 1. Autism | ___ 6. Emotional Disorder |
| ___ 2. Behavior Disorder | ___ 7. Mental Illness |
| ___ 3. Brain Injury | ___ 8. Neurological Impairment |
| ___ 4. Delinquency | ___ 9. Sociopathological |
| ___ 5. Deviant behavior | ___ 10. Social Maladjustment |

- a. Having been found by a court of law to have violated a law.
- b. Extreme disturbance of the emotional process.
- c. Behavior that displays extreme disregard for and hostility toward society.
- d. Psychological illness.
- e. Relating to the nervous system.
- f. Physical harm to the brain resulting in impaired function.
- g. A condition characterized by extreme lack of ability to communicate and to form human relationships.
- h. Difficulty dealing with society and groups of people.
- i. Presenting behavior which who breaks rules, particularly of a sexual nature.
- j. Display of behaviors which deviate significantly from socially accepted norms.

EXERCISE 1.2: Section I (pp. 61-62)

Answer the following questions in your words.

1. What is the value of a diagnostic label?

2. What is the danger of an inappropriate label?

EXERCISE 2.1: Section 2 (pp. 63-71)

Identify the following initials.

1. FERPA
2. FAPE
3. I.E.P.
4. IDEA

EXERCISE 2.2: Section 2 (pp. 63-71)

Answer the following questions by circling True or False.

1. Under FERPA, parents have the right to request that school records be amended.
____ True ____ False
2. Complaints charging discrimination under Section 504 must be lodged with the U.S. Department of Education. ____ True ____ False
3. Schools may exclude students with serious emotional disorders if there are no programs for them. ____ True ____ False

4. Related services must be provided if they are necessary for a student to benefit from his or her education. ☐ True ☐ False
5. A child with schizophrenia would qualify for services under P.L. 101-476 (IDEA). ☐ True ☐ False
6. In the Lora case, the court provided a precise, legal definition for "serious emotional disorder." ☐ True ☐ False
7. The terms Severe Emotional Disorder and Behavioral Disorder are often used interchangeably to identify the same population. ☐ True ☐ False
8. Under P.L. 101-476 (IDEA) schools must seek out and identify all children with disabilities. ☐ True ☐ False
9. Parent counseling is a related service under P.L. 101-476 (IDEA). ☐ True ☐ False
10. Only the 13 items mentioned in P.L. 101-476 (IDEA) may be considered related services. ☐ True ☐ False

EXERCISE 2.3: Section 2 (pp. 63-71)

Fill in the blanks.

1. Serious emotional disorder is a condition exhibiting one or more of the following characteristics over _____ and to _____ which adversely affects _____ performance.
2. Under P.L. 101-476 (IDEA), the term "serious emotional disorder" includes children who have _____ or _____. The term does not include children who have _____, unless it is determined that they have _____.

EXERCISE 2.4: Section 2 (pp. 63-71)

List three rights that P.L. 101-476 (IDEA) guarantees to your child.

1. _____
2. _____
3. _____

List 3 rights that P.L. 101-476 (IDEA) gives you as a parent acting on behalf of your child.

1. _____
2. _____
3. _____

List the 7 parts of an Individualized Education Program.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

EXERCISE 2.5: Section 2 (pp. 63-71)

In your own words, define the following terms.

1. *Least Restrictive Environment* means _____

2. *Mainstreaming* means _____

3. *A Due Process Hearing* means _____

4. *Inclusion* means _____

EXERCISE 3.1: Section 3 (pp. 72-78)

Reread the section on suspension and expulsion and answer the following questions.

1. For how long may a special education student be suspended?
2. Under what circumstances is a school district prohibited from expelling a student?
3. Under what conditions may a special education student be expelled?
4. What due process rights does a student have when the school system is considering expulsion?
5. When may a school refuse to admit a student?

EXERCISE 3.2: Section 3 (pp. 72-78)

In the following circumstances, do the parents/legal guardians or the school district pay for the school placement?

- _____ 1. MARK attends a day treatment program in an elementary school in his district. Both his parents and school officials agreed to this placement in the Individualized Education Program.
- _____ 2. SALLY lives in a group home and attends school in school district A. Sally's parents have custody of her and live in school district B.
- _____ 3. FRANK attends a residential school for the individuals with emotional disorders. His parents placed him there when they became discouraged with the program in their local school district.
- _____ 4. MIKE's parents both have chronic illnesses and cannot care for him any longer. They want to place him in a private residential facility but cannot afford the total cost. The local school district serves Mike in a classroom with other children with disabilities.
- _____ 5. NIKKI's family lives on a ranch several miles from town. She is bused out of her rural school district (District R) to neighboring School District B for services in a self-contained class for students with severe emotional disorders.

ANSWERS

Exercise 1.1 (p. 81)

1. G
2. J
3. F
4. A
5. I
6. B
7. D
8. E
9. C
10. H

Exercise 1.2 (p. 82)

1. A diagnostic label is useful if it truly describes the problem and leads to helpful treatment and/or educational solutions.
2. Mislabeling is dangerous because it sometimes leads to inappropriate treatment.

Exercise 2.1 (p. 83)

1. Family Educational Rights and Privacy Act (FERPA).
2. Free and Appropriate Public Education (FAPA).
3. Individualized Education Plan (I.E.P.).
4. P.L. 101-476 (IDEA).

Exercise 2.2 (p. 83)

1. True
2. False
3. False
4. True
5. True
6. False

7. True
8. True
9. True
10. False

Exercise 2.3 (p. 84)

1. A long period of time; a marked degree; educational.
2. schizophrenia; autism; social maladjustment; serious emotional disorder.

Exercise 2.4 (p. 84)

Special needs children are guaranteed all of the following rights:

1. The right to an appropriate education, as defined by an Individualized Education Program;
2. The right to education in the least restrictive environment;
3. The right to due process hearings;
4. The right to nondiscriminatory evaluation; and
5. The right to related services such as transportation or therapy.

Parents of children with special needs have the following rights:

1. The right to monitor testing and assessment of the child;
2. The right to examine and correct all records about the child; and
3. The right to be involved in any meetings where decisions about the child's education will be made.

The seven parts of an I.E.P. are:

1. Present level of education performance;
2. Annual goals;
3. Short-term objectives;
4. Statement of specific education and related services to be provided;
5. Description of the extent to which the child will participate in regular education programs and a description of the programs to be provided;
6. Projected dates for initiation of services and the anticipated duration of services;
7. Objective criteria and evaluation procedures.

Exercise 2.5 (p. 85)

1. *Least Restrictive Environment* is the placement of a special education student in the learning situation which is as close as possible to the typical school situation and which still meets the student's unique needs.
2. *Mainstreaming* is the placement of a student who qualifies for special education services in a regular education classroom for some classes and in a separate special education setting for some specialized services.
3. *A Due Process Hearing* is a hearing presided over by an impartial hearings officer in which families and school district personnel have the opportunity to present their sides of a disagreement. The hearings officer renders a decision based upon an analysis of the law and the facts.
4. *Inclusion* is the placement in age-appropriate regular classes in a child's neighborhood school with all necessary supports for students and educators provided within the regular classroom.

Exercise 3.1 (p. 86)

1. 10 days.
2. A school district may not expel a special education student, if it can be demonstrated that the student's misbehavior was a result of his or her disabling condition.
3. A special education student may be expelled if the misbehavior is unrelated to the student's disability, and if there is just cause for expulsion.
4. Due process rights include: notice of charges, notification of parents, right to legal counsel, right to confront and cross-examine witnesses and accusers, right to a transcript of the proceedings, and right to appeal.
5. During the time that school officials are seeking suitable placements, a school may refuse to admit a student who is dangerous to him or herself or to others.

Exercise 3.2 (p. 86-87)

1. **School.** Since the placement was agreed upon in the Individualized Educational Plan (I.E.P.), the cost of the placement is the school's responsibility.

2. **School District A or School District B.** If School District B in which Sally's parents live is able to provide her with an appropriate program, then this home district could argue against having to pay for an out-of-district placement in School District A. The key question in deciding upon which district should pay is the agreement made at the time of the original placement. If the placement in the group home and in School District A was not made upon educational grounds, but to provide an appropriate residential placement, then School District B may not be liable for costs. However, if the placement in the group home and in School District A was based upon a need to find an appropriate educational placement, then School District B is liable for the educational costs of Sally's placement. State laws vary on this type of placement issue, and many states lack any legislation which addresses this type of problem.
3. **Parents or School.** The parents would have to pay for this placement, since they made the decision unilaterally, unless they can demonstrate in a due process hearing or in court that the school district does not have an appropriate placement available.
4. **Parents.** If the local district has an appropriate educational placement for Mike, the district does not have to pay for an out-of-district placement that is made on the basis of need for a change of residence. Again, state rules and regulations may vary on this type of issue.
5. **School District R.** If Nikki's home school district (District R) does not have an appropriate program for her, then District R must pay the costs of an out-of-district placement in School District B.

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CHAPTER FOUR

Glossary

Acronyms

A&D	Alcohol and Drug.
ACCH	Association for the Care of Children's Health. A multidisciplinary association of professionals and parents that promotes quality psychosocial health care for children and their families.
ADD	Attention Deficit Disorder. See Attention-deficit Hyperactivity Disorder. (Page 27)
ADHD	Attention-Deficit/Hyperactivity Disorder. A condition characterized by a failure to remain attentive in various situations, especially in the school and home. Hyperactivity refers to excessive motion or activity. (Page 27)
AMI	Alliance for the Mentally Ill. See NAMI.
ARC	Formerly known as The Association for Retarded Citizens. Support group and program for families with children who have developmental disabilities.
BD	Behavioral Disorder. (Page 67)
CAN	Child Abuse and Neglect.
CAP	Center Accreditation Project. A national certification project for quality child care programs.
CASA	Court-Appointed Special Advocate.
CASSP	Child and Adolescent Services System Program. Program begun by the National Institute of Mental Health, now located in the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, and local communities to plan, develop and implement services for children and adolescents with serious emotional disorders.

CDA	Child Development Associate. Training and certification program for Head Start and child care staff.
CEC	Council on Exceptional Children. Professional organization for persons serving exceptional school age children.
CMHC	Community Mental Health Center. A facility providing local mental health services. May be run by the county or state or be a private, non-profit organization.
CMHS	Center for Mental Health Services (Formally a part of the National Institute of Mental Health, now located in the Substance Abuse and Mental Health Services Administration). A federal agency, part of the United States Department of Health and Human Services, that sponsors research, demonstration, and service activities to increase knowledge and improve services in the field of mental health.
CMI	Chronic Mental Illness.
CP	Cerebral Palsy.
CPS	Child Protective Services. State or county agency responsible for addressing issues of child abuse and neglect.
CSP	Community Support Program. Federally funded programs (through the Center for Mental Health Services) to develop community support systems for adults with long-term psychiatric disabilities.
CYSED	Children and Youth with Serious Emotional Disorders.
CST	Child Study Team. A team consisting of the parents of a child with a disability and professionals serving the child, convened to develop long and short range goals for the child's progress.
DD	Developmental Disability (or Delay). Disabilities which affect a person's development, such as, mental retardation, epilepsy, autism, cerebral palsy or similar disabilities.
DEC	Division for Early Childhood of the Council for Exceptional Children. The professional organization for persons serving preschool children with disabilities.
DHHS	United States Department of Health and Human Services.

DOE	Department of Education (United States or state).
DSM IIIR	Diagnostic and Statistical Manual of Mental Disorders (3rd Edition Revised). A classification system for mental illnesses developed by the American Psychiatric Association. The fourth edition, DSM IV, became available in July 1994.
D.S.W.	Doctorate Degree in Social Work. (Page 38)
EBD	Emotional or Behavioral Disorder.
ED	Emotional Disability or Disorder.
Ed.D.	Indicates Doctoral Degree in Education.
EEG	Electroencephalogram. A test that measures electrical impulses in the brain. (Page 34)
EH	Emotional Handicap.
EHA	The Education for All Handicapped Children Act. See Public Law 94-142.
EPSDT	Early and Periodic Screening, Diagnosis and Treatment. Part of Title XIX Medicaid.
FAA	Families as Allies Project, Research and Training Center, Portland State University, Portland, Oregon.
FAPE	A Free and Appropriate Public Education. (Page 70)
FERPA	Family Educational Rights and Privacy Act (Student School Records Act). Federal regulation governing confidentiality of student records and parental rights of access and consent to release. (Page 69)
FFCMH	Federation of Families for Children's Mental Health. A national organization of families and professionals dedicated to advocacy and systems change for children's mental health.
I & R	Information and Referral.
ICFMR	Intermediate Care Facility for People with Mental Retardation.

IEP	Individualized Education Program. A written plan of services for a child with a disability developed jointly by parents and school personnel as required under Public Law 94-142. (Page 70-71, 77)
IFSP	Individual Family Services Plan. Written objectives for each child 0-2 years of age, addressing both the child's and family's needs in the early intervention program. (Page 71)
LCSW	Denotes certification by a state as a Licensed Clinical Social Worker. Such licensure requires at least two years experience with a direct client caseload under supervision and passing a state examination. (Page 38). Some Social Workers have A.C.S.W. after their names, indicating similar certification from the Academy of Certified Social Workers.
LEA	Local Educational Agency.
LRE	Least Restrictive Environment. (Page 74)
MBD	Minimal Brain Dysfunction.
MED	Mental or Emotional Disability (or Disorder).
MHA	Mental Health Association. A non-profit citizens organization dedicated to legislative advocacy on behalf of people with mental illness and children with disorders. Other services include public education and prevention of abuse and family problems and sponsorship of parent support groups.
MI	Mental Impairment/Illness.
MMPI	Minnesota Multiphasic Personality Inventory. A personality assessment tool widely used in making psychological evaluations. Normally given to persons 16 years of age and older.
MPB	Migrant Program Branch. A federal Head Start program serving Native American children who reside on reservations and migrant children.
MPH	Indicates a Master's Degree in Public Health.
MR	Mental Retardation.
MR/DD	Mental Retardation/Developmental Disability (or Delay or Disorder).
M.S.W.	Master's Degree in Social Work. (Page 38)

- NAEYC** **National Association for the Education of Young Children.** A professional organization for persons in early childhood education.
- NAMI** **National Alliance for the Mentally Ill.** A self-help organization of persons with mental illness, their families and friends.
- NAMI-CAN** **National Alliance for the Mentally Ill—Child and Adolescent Network.** NAMI'S self-help organization for families of children with emotional and mental disorders.
- NICHCY** **National Information Center for Children and Youth with Disabilities.** A free information service that assists parents, educators, caregivers and others in ensuring that all children and youth with disabilities have a better opportunity to reach their fullest potential.
- NIDRR** **National Institute on Disability and Rehabilitation Research.** A federal agency that funds research and services for persons with physical or mental disabilities. Part of the United States Department of Education.
- NIMH** **National Institute of Mental Health,** which formerly housed federal mental health training programs now located in the Center for Mental Health Services.
- NMHA** **National Mental Health Association.** See MHA.
- OT** **Occupational Therapy.**
- P & A** **Protection and Advocacy.** State agency providing advocacy activities on behalf of persons with developmental disabilities and mental illness. See Public Law 99-319.
- PDD** **Pervasive Developmental Disorder.** (Page 27)
- Ph.D.** Indicates a doctoral degree in any of a wide range of disciplines (e.g., sociology, psychology, anthropology, mathematics, etc.)
- PIC** **Parent Information Center.** Parent information and support programs funded by the United States Department of Education.
- PT** **Physical Therapy.**
- PTI** **Parent Training and Information Centers.** See PIC.
- R & R** **Resource and Referral.**

R & T	Research and Training Center (or R & T Centers). Centers funded by NIDRR to provide research, training and technical assistance to consumers with disabilities and service providers. Two centers focus on the needs of children and youth with emotional disorders. These two centers are also supported by CMHS and are located at the University of South Florida and at Portland State University in Oregon. See RRTC.
RN	Registered Nurse. (Page 38)
RRC	Regional Resource Centers. Federally-funded programs responsible for training and technical assistance to staff who serve school age children with disabilities.
RRI	Regional Research Institute for Human Services, Portland State University, Portland, Oregon.
RRTC	Rehabilitation Research and Training Center. Federally funded programs to provide training to professionals and informational and technical assistance resources to individuals with disabilities and their families. See R & T.
SAMHSA	Substance Abuse Mental Health Services Administration, U.S. Department of Health and Human Services.
SAT	Standardized Achievement Test.
SEA	State Educational Agency.
SED	Serious Emotional Disability (or Disorder). Also commonly EH for "emotional handicap," or EBD for "emotional or behavioral disorder."
SMHRCY	State Mental Health Representatives for Children and Youth. The professional people in each state responsible for the planning, development and management of public child mental health services. A division of the National Association of State Mental Health Program Directors.
SS	Social Services.
SSA	Social Security Administration. A federal agency that administers social security and disability benefits.
SSDI	Social Security Disability Insurance. A federal program administered by SSA.

- SSI** **Supplemental Security Income.** A federal program administered by SSA.
- VR** **Vocational Rehabilitation.** Also commonly VRD or DVR; "D" for Department.
- WISC** See **Wechsler Tests** in Terms section of glossary.
- WRAT** **Wide Range Achievement Test.** A short test for evaluating basic skills of spelling, arithmetic and reading. The WRAT is widely used by schools for testing educational achievement.

Laws and Regulations

Public Law (P.L.) 94-142 (1975). The original Individuals with Disabilities Education Act. Commonly known as The Education for All Handicapped Children Act. A federal law that guarantees a free, appropriate public education for all children with disabilities. Also known as 94-142.

Public Law (P.L.) 96-272 (1980). Adoption Assistance and Child Welfare Act of 1980. Federal law outlining procedures for the placement of children out of home by state child welfare agencies.

Public Law (P.L.) 96-389 (1980). Mental Health Systems Act. Encourages the development of systems of care. Policies contained in the Act received no specific funding.

Public Law (P.L.) 99-319 (1986). Protection and Advocacy for Mentally Ill Individuals Act of 1986. Federal law allocating funds to each state for advocacy activities on behalf of persons with developmental disabilities or mental illness.

Public Law (P.L.) 99-457 (1986). Individuals with Disabilities Education Act Amendment of 1986. Guarantees free appropriate early intervention (birth through age two) (Part H) and special education (age three to twenty-one) (Part B).

Public Law (P.L.) 101-336 (1990). American with Disabilities Act.

Public Law (P.L.) 102-119 (1991). Amendment and Reauthorization of IDEA.

(1990) Individuals with Disabilities Education Act (IDEA). Guarantees free appropriate early intervention (Part H) and special education (Part B).

Public Law (P.L.) 102-321. Child Mental Health Services Program.

Section 504. A part of the Rehabilitation Act of 1974. This section states that no program or activity receiving federal funds can exclude, deny benefits to, or discriminate against any person on the basis of disability. It also requires access for people who have disabilities to all public buildings. Also known as 504.

Title IV-E. Also known as Public Law (P.L.) 96-272 or Title IV-E of The Social Security Act.

Title XIX (19). Federal program of medical aid designed for those unable to afford fee for service medical care (Medicaid). With a Medicaid card, individuals can purchase medical service as needed in the community. Part of the Social Security Act.

Title XX (20). Federal program supports social services at the state and local level contingent on the development of a plan which includes the goals and target groups for such services. Part of the Social Security Act.

Terms

Acting Out. Self-abusive, aggressive, violent and/or disruptive behavior. (Page 3)

Acute. Marked by a sudden onset, sharp rise, and lasting a short time, demanding urgent attention.

Adjudicated. Coming under the protection or guardianship and jurisdiction of the court. (Page 85)

Adjustment Disorder. Extreme reactions in adolescents to social demands for establishing personal identity and independence from family. (Page 30)

Advocacy. The process of actively supporting the cause of an individual (case advocacy) or group (class advocacy), speaking or writing in favor of, or being intercessor or defender. Action to assure the best possible services for or intervention in the service system on behalf of an individual or group. (Page 13)

Affect. Feeling, emotion.

Affective. Related to or arising from feelings and emotions.

Affective Disorder. A disorder of mood (feeling, emotion). Refers to a disturbance of mood and other symptoms that occur together for a minimal duration of time and are not due to other physical or mental illness. (Page 30)

Anxiety Disorder. Exaggerated or inappropriate responses to the perception of internal or external dangers. (Page 31)

Appropriate Education. An individual education program specially designed to meet the unique needs of a child who has a disability. (Page 70)

Assessment. See Evaluation.

Attachment Disorder. An attachment disorder is a condition in which individuals have difficulty forming loving, lasting, intimate relationships. (Page 29)

Attention Deficit Disorder (ADD). The essential features of this disorder are developmentally inappropriate degrees of inattention, impulsiveness and sometimes hyperactivity.

Autistic Disorder. A disorder (usually appearing by age 3) characterized by lack of communication, lack of social skills, withdrawal and developmental delays. (Page 27)

Avoidance. A symptom of a disorder manifested by avoiding the establishment of new interpersonal contacts to the extent that social functioning is impaired.

Behavioral Disorder. A disorder characterized by displaying behaviors over a long period of time which significantly deviate from socially acceptable norms for the individual's age and situation. (Page 67)

Bipolar Disorder. A mood disorder with elevated mood, usually accompanied by a major depressive episode. (Page 30)

Brain-Injury. A condition in which an individual before, during, or after birth has received an injury to or suffered an infection of the brain. As a result of such organic impairment, there may be disorders that prevent or impede the normal learning process.

Care Coordination. Brokering services for an individual to ensure that their needs and met and their services are not duplicated by the organizations involved in providing care.

Capitated Rates. Rembursement by insurance companies to care providers that has predetermined amount (cap) of dollars for rendered services.

Case Change. Changing the services for an individual.

Case Management. A service that assists clients to obtain and coordinate community resources such as income assistance, education, housing, medical care, treatment, vocational preparation, and recreation.

Case Manager. An individual who organizes services for a client.

Child Psychiatrist. A physician (M.D.) specializing in mental, emotional, or behavior disorders in children and adolescents. Qualified to prescribe medications. (Page 37)

Child Psychologist. A mental health professional with a Ph.D. in psychology who administer tests, evaluates and treats children's emotional disorders. Cannot prescribe medication. (Page 37)

Child Welfare. A field of social service concerned with the care and well being of children.

Child Welfare Agency. An administrative organization providing protection to children, and supportive services to children and their families.

Childhood Depression. See **Major Depression and Depression.**

Chronic. Marked by long duration or frequent recurrence.

Clinical Social Worker. A mental health professional trained to provide services to individuals, families, and groups. Cannot prescribe medication. (Page 38)

Collaboration. A helping relationship between a family member and a professional in a reciprocal relationship in which the family and professional share power and responsibility. The relationship is grounded in the belief that the family of a child with an emotional disorder can be a resource to the professional and vice versa.

Community-Based Services. The practice of having the locus of services as well as management and decision-making responsibility at the community level.

Community Support System. An organized system of care to assist adults with long-term psychiatric disabilities to meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community.

Conduct Disorder. Repetitive and persistent patterns of behavior that violate either the rights of others or age appropriate social norms or rules. (Page 28)

Cultural Competence. An awareness and acceptance of cultural differences, an awareness of one's own cultural values, an understanding of the "dynamics of difference" in the helping process, basic knowledge about the client's culture, and the ability to adapt practice skills to fit the client's cultural context.

Custody Relinquishment. The practice of requiring parents to surrender one's child into the custody of the state in order to obtain services at public expense.

Day Treatment. Community-based, non-residential program of services for children with emotional disorders. It is the most intensive program available that still allows the child to remain in the home. (Page 43)

Defensive Behavior. Behavior that is for the purpose of protecting the individual or avoiding unpleasant ideas, thoughts, and consequences. (Page 3)

Delinquency. Violation of law by a child or youth (usually under 18).

Depression. A type of mood disorder characterized by low or irritable mood or loss of interest or pleasure in almost all activities over a period of time. (Page 30)

Developmental Disorders. Disorders that have predominate disturbances in normal development of language, motor, cognitive and/or motor skills.

Deviant Behavior Breaking formal or informal rules or laws relative to social customs or norms, including sexual behavior.

Dual Diagnosis. A diagnosis of an emotional disorder and another disorder such as developmental delay, drug and alcohol use or a mental illness.

Due Process Hearing. A formal legal proceeding presided over by an impartial public official who listens to both sides of the dispute and renders a decision based upon the law. (Page 76,79)

Eating Disorders. Disorders that are manifested by gross disturbances in eating behavior, including anorexia nervosa and bulimia. (Pages 32,33)

Elimination Disorders. The essential feature of these disorders are the lack of control over bladder (enuresis) or bowel (encopresis) not caused by a physical disorder.

Emotional Disorder (or Disability). Behavior, emotional, and/or social impairment exhibited by a child or adolescent that consequently disrupts the child's or adolescent's academic and/or developmental progress, family, and/or interpersonal relationships. (Page 67,68,71)

Empowerment. The ability to exercise influence and control over the services one's child receives.

Enuresis/Encopresis. See **Elimination Disorders.**

Evaluation. A process conducted by mental health professionals which results in an opinion about a child's mental or emotional capacity, and may include recommendations about treatment or placement. See **Assessment.**

Exceptional Children. Children whose performance deviates from the norm (either above or below) to the extent that special programming is needed.

Family Support Program. Programs available in the community that assist children and their families so that children can remain in their homes, and all members of the family can live balanced, healthy lives.

Family Therapy. A treatment model that involves interaction with family members and family interactions as well as with the individual.

Federation of Families for Children's Mental Health. A parent-run organization focused on the needs of children and youth with emotional, behavioral or mental disorders and their families.

Guidance Counselor. An individual working in a school who is trained to do screening, evaluations, and career and academic advising. (Page 38)

Identity Disorder. Severe subjective distress caused by child's inability to achieve an integrated sense of self. (Page 30)

Inclusion. An educational option for students with disabilities to be educated in a regular classroom in their neighborhood school with all necessary supports provided so that the student can participate fully.

Individualized Education Program (IEP). A federally mandated written individual plan of services for all children with disabilities who qualify for special education. It is developed jointly by parents and school personnel. (Page 70-71,77)

Inpatient. Services received while residing in the hospital or residential care facility.

Learning Disorder. A chronic condition that interferes with development, integration and/or demonstration of verbal and/or non-verbal abilities.

Least Restrictive Environment. An educational, treatment or living situation that provides appropriate services or programs for a child with disabilities while imposing as few limitations or constraints as possible. (Page 74,78)

Mainstreaming. Placement of a child with a disability in the regular classroom for part of the school day. (Page 78)

Major Depression. A mood disorder with a depressed affect. (Page 30)

Managed Care. A system of care that oversees all services to an individual to ensure that proper treatment is provided and treatment is not duplicated.

Medicaid Title XIX (19) funding for medical services for individuals receiving public assistance, or who have vision impairments or disabilities.

Mental Illness. General term applied to severe emotional problems or psychiatric disorders. (Page 68)

Neurological Impairment. Damage or deficiency to the nervous system of the body. (Page 34)

Neurologist. A physician (M.D.) specializing in diagnosis and treatment of diseases of the nervous system. (Page 35)

Obsessive Compulsive Disorder. An anxiety disorder manifested by intrusive and persistent thoughts (obsessions) or impulses and compulsive behaviors or rituals (compulsions).

Oppositional Disorder. The covert display of underlying aggression by patterns of obstinate, but generally passive behavior. Children with this disorder often provoke adults or other children by the use of negativism, stubbornness, dawdling, procrastination, and other behaviors. (Page 32)

Outpatient. Treatment available in the community at a local mental health clinic or from private therapists. Children receiving this type of treatment generally live at home. (Page 43)

Parent Training:

1. Classes or individual instruction designed to improve parenting skills in such areas as discipline, consistency, and communication; and
2. Parent Training and Information (PTI) provides information and assistance to parents so they can be knowledgeable and effective advocates within service and policy systems.

Pediatric RN. A registered nurse specializing in the care of children.

Pervasive Developmental Disorder. Extreme distortions or delays in the development of social behavior and language. (Page 27)

Phobic Disorders. Disorders that cause extreme and irrational anxiety when encountering particular situations, objects or activities

Post-Traumatic Stress Disorder (PTSD). Anxiety disorder following a traumatic event. (Page 31)

Psychiatric Nurse. A registered nurse specializing in the care of patients with emotional or psychiatric disorders. (Page 38)

Psychiatric Social Worker. Social worker specializing in work with psychiatric patients and their families. (Page 38)

Psychiatrist. A physician (M.D.) specializing in mental, emotional, or behavioral disorders. Qualified to prescribe medications. (Page 37)

Psychoanalyst. A person who diagnoses and treats emotional disorders through special techniques that explore a patient's mental and emotional history and makeup. This approach to treatment is usually long term. (Page 37)

Psychologist. See Clinical Psychologist.

Psychosis. A general term used to describe any of several mental disorders characterized by social withdrawal, distortions of reality, loss of contact with environment and disintegration of personality.

Psychotherapist. A mental health professional who provides psychotherapy. (Page 37)

Psychotherapy. A broad term applied to a variety of approaches to the treatment of mental and emotional disorders. (Page 25)

Residential Treatment. Live-in facilities that provide treatment and care for children with emotional disorders who require continuous medication and/or supervision or relief from environmental stresses. (Pages 44)

Respite Services. Temporary care given to an individual for the purpose of providing a period of relief to the primary caregivers. Respite is used to decrease stress in the homes of persons with disabilities or handicaps, thereby increasing caregivers' overall effectiveness. (Page 46-48)

Schizophrenia. A serious mental disorder characterized by verbal incoherence, severely impaired interpersonal relations, disturbance in thought processes, cognitive deficits, and inappropriate or blunted affect. The child may also exhibit hallucinations or delusions. (Page 29)

School Phobia. Fear of going to school associated with anxiety about leaving home and family members.

School Psychologist. A mental health professional who works in schools. (Page 38)

School Social Worker. A social worker who works in schools. (See **Social Worker**)

Screening. An assessment or evaluation for the purpose of determining the appropriate services for a client.

Serious Emotional or Behavioral Disability/Disorder. Emotional and/or social impairment in a child or adolescent that consequently disrupts the child's or adolescent's academic and/or developmental progress, family and/or interpersonal relationships, and has impaired functioning that has continued for at least one year, or has an impairment of short duration and high severity. (Page 67,68,71)

Service Coordination. See Case Management.

Simple Phobia. Characterized by persistent irrational fears of a specific object, activity, or situation.

Social Worker. A professional trained to provide services to individuals, families, and groups. (Page 38)

Social Maladjustment. Extreme difficulty dealing appropriately with other people. (Page 68)

Sociopath. A term sometimes used to describe persons with extreme disregard for and hostility toward society.

Somatization Disorders. A symptom found in a number of childhood disorders in which psychological or social factors contribute to physical symptoms. (Page 28)

Status Offense. Non-criminal behavior of a child such as running away, truancy, and curfew violation, that can result in juvenile court action.

Substance Abuse/Dependence. The misuse of alcohol or drugs.

Support Services. Transportation, financial help, support groups, homemaker services, respite services, and other specific services to children and families.

Systems of Care. A comprehensive spectrum of mental health and other necessary services are organized into a coordinated network to meet the multiple and changing needs of children with emotional disorders.

Systems Change. Making modifications in the way policy and procedures are made or services are delivered across multiple programs or agencies.

Tourette's Syndrome. A neurological disorder characterized by involuntary muscular movements, uncontrollable vocal sounds, and inappropriate words.

Transition. The change from using children's services to using adult services, moving from one program to another, starting or leaving school, or other important life changes.

Transition Services. Services needed by youth in transition, such as:

- Independent Living Skills
- Career Education
- Interpersonal Relationship Skills
- Leisure Time Training
- Vocational Training
- Job Placement
- On-Site Supervision
- Supervised Apartment Living

Treatment. Changing behaviors or other conditions related to the child's emotional or behavioral disorder; and/or helping the individual and his or her family to cope with the disability.

Treatment Modality. The method that is used to treat a child; for example, behavior management is one treatment modality and play therapy is another.

Wechsler Tests. A series of verbal and performance tests widely used in school systems. Three types are used:

1. WPPSI: The Preschool and Primary Scale of Intelligence;
2. WAIS-R: The Adult Intelligence Scale (Revised); and
3. WISC or WISC-R: The Intelligence Scale for Children (Revised).

Withdrawing Behavior. Behavior characterized by reduced interest in or contact with other people, and can include absence of speech, regression to babyhood, exhibition of many fears, depression, refusing contacts with other people.

Wraparound Services. The coordination of delivery of services to children and their families that is individually tailored to each case with the goal of keeping the family together in the community and being included in normalized school settings.

Glossary Acknowledgements

The majority of the information in this glossary is taken from the text of *Taking Charge*. Page numbers after terms in the glossary refer to pages in this publication. Additional definitions were taken from the Idaho Child and Adolescent Services System Program (CASSP) Glossary or were contributed by staff members of the Research and Training Center on Family Support and Children's Mental Health.

Certain acronyms were defined by staff members of their organizations. Some of these were Mental Health Association (MHA), defined by Diane Luther of the Salem, Oregon, Mental Health Association; Migrant Program Branch (MPB), defined by Penny Hinkley of the Oregon Migrant and Indian Coalition Head Start, a Migrant Program Branch organization; State Mental Health Representatives for Children and Youth (SMHRCY), defined by Lenore Behar, Ph.D., Chief, Child Mental Health Services, North Carolina Department of Human Resources; and anonymous authors of brochures distributed by the National Information Center for Children and Youth with Disabilities (NICHCY) and the Association for the Care of Children's Health (ACCH). Certain terms were defined by experts in the field. These include the definition of "exceptional children" by Richard J. Sonnen, Ed.D., Department Head, Special Studies, Portland State University, Oregon; "community support system" by the Department of Health and Human Services Steering Committee on the Chronically Mentally Ill, 1980; and "emotional disability," "serious emotional disorder," and "behavior disorder" by Vermont Child and Adolescent Services System Program (CASSP). The definitions of "schizoid disorder" and "schizophrenic disorder" are taken from *Behavior Disorders in Infants, Children, and Adolescents* edited by John M. Reisman (1986), New York: Random House. Another reference source is *Women and Psychotherapy: An Assessment of Research and Practice* edited by Annette Brodsky and Rachel Hare-Mustin (1980), New York: Guilford Press.

The Research and Training Center Staff offered suggestions on the content of the glossary and assisted in locating and defining acronyms and terms. Marilyn McManus proofread the glossary and offered suggestions for its improvement. Barbara Friesen originated the idea of developing a glossary of acronyms and terms as a service to families of children with emotional disorders.

APPENDIX

RESOURCES ON CHILDREN'S MENTAL HEALTH

American Academy of Child and
Adolescent Psychiatry
3615 Wisconsin Avenue, N.W.
Washington, D.C. 20016
(202) 966-7300

American Anorexia/Bulimia
Association, Inc.
418 E. 76th Street
New York, NY 10021
(212) 734-1114

Anxiety Disorder Association of
America
6000 Executive Boulevard, #200
Rockville, MD 20852-3883
(301) 231-9350

ARC National Headquarters
(formerly The Association for
Retarded Citizens)
500 East Border Street, Suite 300
Arlington, TX 76010
(817) 261-6003

ARCH National Resource Center
(Access to Respite Care and Help)
Chapel Hill Training-Outreach
Project
800 Eastowne Drive, Suite 105
Chapel Hill, NC 27514
(919) 490-5577
1-800-473-1727
FAX: (919) 490-4905

Association for Children with
Learning Disabilities
4165 Library Road
Pittsburgh, PA 15234
(412) 341-1515

Bazelon Center for Mental Health
Law
1101 15th Street, N.W.
Suite 1212
Washington, DC 20005-5002
(202) 467-5730; (202) 467-4232
FAX: (202) 223-0409

CASSP Technical Assistance
Center
(Child and Adolescent Service
System Program)
Georgetown University
2233 Wisconsin Avenue, N.W.
Washington, DC 20007
(202) 338-1831

Children's Defense Fund (CDF)
25 E. Street, N.W.
Washington, DC 20001
(202) 628-8787

Children with Attention Deficit
Disorder
CHADD
499 N.W. 70th, Suite 308
Plantation, FL 33317
(305) 587-3700

Council on Anxiety Disorders
P.O. Box 17011
Winston-Salem, NC 27116
(919) 722-7760

Exceptional Parent Magazine
1170 Commonwealth, 3rd Floor
Boston, MA 02134-4646
(617) 730-5800
FAX (617) 730-8742

Federation for Children with Special
Needs
312 Stuart Street, Second Floor
Boston, MA 02116
(617) 482-2915

Federation of Families for Children's
Mental Health
1021 Prince Street
Alexandria, VA 22314-2971
(703) 684-7710

Information Exchange on Young
Adult Chronic Patients
20 Squadron Boulevard, Suite 400
New City, NY 10956
(914) 634-0050
FAX (914) 634-1690

Mental Health Policy Resource
Center
1730 Rhode Island Avenue, N.W.
Suite 308
Washington, DC 20036-3101
(202) 775-8826

National Alliance for the Mentally Ill
Children and Adolescents Network
(NAMI-CAN)
2101 Wilson Boulevard, Suite 302
Arlington, VA 22201
(703) 524-7600

National Anorexic Aid Society
Harding Hospital
1925 E. Dublin Granville Road
Columbus, Ohio 43229
(614) 436-1112

National Association of Anorexia
Nervosa & Associated Disorders,
Inc.
P.O. Box 7
Highland Park, IL 60035
(708) 831-3438

National Association of Protection
and Advocacy Systems (NAPAS)
900 Second Street, N.E., Suite 211
Washington, D.C. 20002
(202) 408-9514

National Autism Society of America
8601 Georgia Avenue, Room 503
Silver Springs, MD 20910
(301) 565-0433

National Center for Youth with
Disabilities
University of Minnesota-Box 721
420 Delaware Street S.E.
Minneapolis, MN 55455
(612) 626-2825; (612) 624-3939
1-800-333-6293

National Depressive and Manic
Depressive Association
Merchandise Mart-Box 3395
Chicago, IL 60654
(312) 939-2442

National Information Center for
Children and Youth with
Disabilities (NICHCY)
1233 20th Street, N.W., Suite 504
Washington, D.C. 20036-2304
(202) 416-0300; (202) 416-0318
TDD 1-800-695-0285
FAX (202) 416-0312

National Mental Health Association
(NMHA)
11 A-33 Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
(301) 443-4513

National Parent Network on
Disabilities
1600 Prince Street, #115
Alexandria, VA 22314
(703) 684-6763 TDD/V

National Society for Children and
Adult with Autism
1234 Massachusetts Avenue, N.W.,
Suite 1017
Washington, DC 20005
(202) 783-0125

Obsessive Compulsive Foundation
P.O. Box 70
Milford, CT 06460
(203) 878-5669

Office of Civil Rights-U.S.
Department of Education
Switzer Building, Suite 5000
330 C. Street, S.W.
Washington, DC 20202-1328
(202) 708-5366

Research and Training Center for
Children's Mental Health
Florida Mental Health Institute
13301 Bruce B. Downs Boulevard
Tampa, FL 33612-3899
(813) 974-4657

Social Security National Office
Supplemental Security Income (SSI)
1-800-772-1213
Zebley Implementation Office
1-800-523-0000

Tourette Syndrome Association, Inc.
42-40 Bell Boulevard
Bayside, NY 11361
(718) 224-2999
1-800-237-0717

For a state-by-state resource guide, you may want to order the *National Directory of Organizations Serving Parents of Children and Youth with Emotional and Behavioral Disorders* from the Research and Training Center on Family Support and Children's Mental Health.

TAKING CHARGE:
A Handbook for Parents Whose Children
Have Emotional Disorders

EVALUATION FORM

1. Who used the handbook? (Check all that apply)
☐ Parent ☐ Educator ☐ Child Welfare Worker
☐ Juvenile Justice Worker ☐ Mental Health Professional
☐ Other (Please specify) _____
2. Please describe the purpose(s) for which you used the handbook:

3. Would you recommend use of the handbook to others? (Check one)
☐ Definitely ☐ Maybe ☐ Conditionally ☐ Under No Circumstances
Comments: _____
4. Overall, I thought the handbook was: (Check one)
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Comments: _____
5. Please offer suggestions for the improvement of subsequent editions of this handbook:

We appreciate your comments and suggestions. Your feedback will assist us in our effort to provide relevant and helpful materials. Thank you.

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